

THE BOSTON Medical and Surgical JOURNAL

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The Massachusetts Medical Society

PROCEEDINGS OF THE SOCIETY

First Day, Monday, June 6, 1927

THE first day of this, the first three-day-meeting of the Society, was devoted to clinics, at the various hospitals of the city of Boston, in the morning, and at the Hotel Statler in the afternoon, where Richard C. Cabot, Frank H. Lahey and John Lovett Morse gave diagnostic clinics in medicine, surgery and pediatrics, respectively. All the clinics were well attended, those at the hospitals drawing over 350 physicians. In the evening about 1400 Fellows and their families attended the "Pops" concert in Symphony Hall, as guests of the Society.

Second Day, Tuesday, June 7, 1927

In the morning the Sections of Surgery and Pediatrics held their meetings in the Hotel Statler and at 11:30 the Supervising Censors met for their annual meeting in Parlor D. on the mezzanine floor. Nine supervisors were present; a committee to prepare examination papers was elected and the plan of examination discussed. At noon the Council met in the Georgian Room, the attendance being 147. (See Proceedings of the Council.) Following the Council meeting there was a general buffet luncheon to Fellows in the Ball Room. During the afternoon the Sections of Obstetrics and Gynecology and Tuberculosis met in the hotel and in the evening the Shattuck Lecture was given in the Ball Room by Philemon E. Truesdale of Fall River, his subject being *Group Practice*. After the lecture Timothy Leary, Medical Examiner of Suffolk County, gave a talk entitled: *Studies from the Practice of a Medical Examiner*, that held the attention of a large audience for over an hour.

Third Day, Wednesday, June 8, 1927

The morning of the third day was occupied by the meetings of the Sections of Medicine and of Radiology and Physiotherapy in the rooms of the hotel. Shortly after noon the President called to order in the Assembly Room the annual meeting of the Society. The record of the last meeting was read by the Secretary, and, as

there were no errors or omissions noted the minutes stood as read. The Secretary stated that on June 9, 1926 the total membership of the Society was 4287. During the year the Society had lost, by death 72; by resignation 12; by deprivation of the privileges of fellowship (under clauses (a) and (b), of Section 8, Chapter I) 15; by deprivation (under clause (c) of the same section) 2, making a total loss of 101. During the year the Society had gained Fellows as follows: new Fellows 170; readmitted by the censors 1; restored by the Council 8, making a total gain of 179, a net gain of 78, therefore the membership on June 8, 1927 was 4365. The President read the following amended clause (c) of Section 8, Chapter I, of the By-Laws, that had been approved by the Council at its stated meeting on October 6, 1926, and had been published in the official program of the meeting:

(c) Fellows who have been convicted in a court of law of a crime or misdemeanor involving moral turpitude may be deprived of the privileges of fellowship by the council acting on separate reports of the committee on ethics and discipline and the committee on membership and finance, presented by the latter committee. Before a fellow shall be so recommended for deprivation, he shall have the privilege of a hearing by the joint committee if he desires.

Fellows who have been deprived of the privileges of fellowship, on making application in writing to the council to be restored to said privileges, shall receive the consideration of the council. Such petitions should be addressed to the council and sent to the secretary of the general society.

On motion by David Cheever, duly seconded, it was *Voted*, That the present clause (c) Section 8, Chapter I, of the By-Laws be, and it is rescinded hereby and that the clause (c) as read, be and it is hereby adopted. There being no incidental business the chair called on Herbert L. Newell of East Randolph, Vermont, who brought greetings from the Vermont State Medical Society. He said that he began the study of medicine in a Massachusetts hospital; that that state and Vermont have many things in common. Massachusetts has adopted Vermont's most eminent son and all in Vermont feel proud of him. Last October the Vermont Society was

glad to see the President of the Massachusetts society and other delegates and most cordial relations had been cemented. He had enjoyed the meetings in the Statler and was happy to be present.

According to the vote of the Council, June 7, Victor Safford read the report of the standing Committee on Public Health and it was accepted with applause. Dr. Cheever moved a vote of thanks to the Committee of Arrangements for such a successful meeting and it was so voted. The president added his personal thanks. About 100 were in the audience at this time.

After a short intermission the annual discourse was delivered by William H. Rose, of Worcester, with the subject: *Industrial Surgery*. F. B. Lund moved a vote of thanks to the orator that was seconded by C. M. Green who said that the orator had been a student of his in the medical school and that this year marked the fiftieth anniversary of his, Dr. Green's, becoming a Fellow of the Society. The vote was unanimous.

The annual dinner was served in the Ball Room to 481 Fellows and their guests. The speakers were Rev. Samuel McChord Crothers, clergyman, writer, of Cambridge, State Representative Henry L. Shattuck of the Boston Bar and Dr. George H. Bigelow, Massachusetts Commissioner of Public Health, besides the president, who at the close introduced his successor, Dr. John M. Birnie, of Springfield. The annual meeting was adjourned at 4:40 o'clock p. m.

A commercial exhibit by twenty exhibitors was carried on in the hotel during the three days of the meeting. The total registration during the three days was 1238. The complete program of the annual meeting was printed in the *Boston Medical and Surgical Journal*, May 26, 1927, Vol. 196, pp. 847-864.

The attendance at the Section meetings and the officers elected for the following year were as follows:

SECTION OF MEDICINE: Attendance, about 100. Officers elected for 1928: William R. Ohler, Boston, *Chairman*; Albert E. Parkhurst, Beverly, *Secretary*.

SECTION OF SURGERY: Attendance about 350. Officers elected for 1928: Frederick B. Sweet, Springfield, *Chairman*; Walter C. Seelye, Worcester, *Secretary*.

SECTION OF TUBERCULOSIS: Attendance about 90. Officers elected for 1928: John B. Hawes 2d, Boston, *Chairman*; Walter A. Griffin, Sharon, *Secretary*.

SECTION OF PEDIATRICS: Attendance about 125. Officers elected for 1928: Kenneth D. Blackfan, Brookline, *Chairman*; Joseph Garland, Boston, *Secretary*.

SECTION OF OBSTETRICS AND GYNECOLOGY: Attendance about 300. Officers elected for 1928: Foster S. Kellogg, Boston, *Chairman*; Frederick L. Good, Boston, *Secretary*.

SECTION OF RADIOLOGY AND PHYSIOTHERAPY: Attendance about 400. Officers elected for 1928:

Frederick W. O'Brien, Boston, *Chairman*; William D. McFee, Haverhill, *Secretary*.

WALTER L. BURRAGE,
Secretary.

ADMISSIONS RECORDED FROM JUNE 9, 1926, TO JUNE 8, 1927

Year of Admission	Name	Residence	Medical College
1927	Andrews, John Henry.	Hyannis.	11
1926	Andrews, John Raymond.	Pittsfield.	22
1927	Angell, Edwin Olin.	Springfield.	12
1926	Armstrong, Jane Buckingham.	Northampton	15
1927	*Bailey, Florence.	Lawrence.	2
1926	Balch, Franklin Greene, Jr.	Roxbury.	11
1926	Banas, Felicia Anne.	Roxbury.	12
1926	Bard, Henry Herbert.	Pittsfield.	2
1927	Bartlett, William Bradford.	Concord.	11
1926	Beauchamp, Eugene Wilfrid.	Chicopee.	20
1927	*Beaupré, Dolor Israel.	Holyoke.	28
1927	Becher, George David.	Springfield.	12
1927	Berlin, David Daniel.	Dorchester.	12
1927	*Blumerfeld, Israel Michael.	Boston.	27
1927	*Bogan, Mary Elizabeth.	Beverly.	14
1927	Bolen, Henry Leonard.	Fall River.	5
1926	*Boruchoff, Henry.	Dorchester.	27
1926	Boss, Eugene George.	Boston.	16
1926	Boyle, Hubert Allan.	Middleton.	24
1927	Branch, Charles Franklin.	Allston.	22
1927	*Brewin, John Andrew.	Everett.	6
1926	Brindamour, Jean Louis Edmond.	Holyoke.	20
1926	Britton, Edgar Murray.	Quincy.	32
1926	Brown, Byron Freeman.	Worcester.	10
1927	Brown, Charles Leonard.	Roxbury.	26
1927	Brown, Howard Bryden.	Springfield.	19
1926	*Bulian, Moses.	Boston.	36
1927	Burack, Abraham.	Brocton.	12
1927	Burke, Edmund Byron.	Newtonville.	10
1927	Burns, James Francis.	Somerville.	12
1926	Burns, Thomas Francis.	Fall River.	20
1927	Calderwood, Samuel Herbert.	Roxbury.	10
1926	Canavan, Myrtelle May.	Roxbury.	14
1926	Cariani, Mario John.	Springfield.	12
1926	Card, Walton Gardner.	Haverhill.	12
1927	Carlisle, Paul Edward.	Springfield.	19
1927	*Carter, Albert Arthur.	Malden.	27
1927	Chandler, Charles Henderson.	Medford.	12
1927	Clewley, William Hale.	Woburn.	10
1927	*Coelho, Thome Emilio Pires.	Fall River.	37
1926	Coleman, William Levin.	Smithtown, N. H.	20
1927	*Copeland, Lena Wallace.	Brocton.	27
1926	Costa, Raymond Rapozo.	Fall River.	12
1926	Covner, Albert Henry.	Lynn.	12
1926	Cowan, Eleanor Elisabeth.	Roxbury.	12
1927	Craft, Harry Leolyn.	Ashfield.	22
1926	Cramton, Edward Allen.	Pittsfield.	21
1926	Brewster, James Hiram.	Attleboro.	19
1926	Creed, John Patrick.	Haverhill.	11
1927	Cronin, Edward Joseph.	Allston.	12
1926	Corsini, Tonino Vincent.	Quincy.	10
1927	Curtis, Walter Stanley.	Boston.	11
1926	DeArmit, Lillian.	Roxbury.	10
1926	Devine, Bernard Francis.	Boston.	11
1926	Edmands, Amy Harriet.	Webster.	3
1926	Ekwall, Thorsten Roland.	So. Ashburnham	12
1927	Epstein, Joshua.	Salem.	12
1927	Erlund, Carl Helge.	Boston.	11
1927	Evans, Maurice George.	Roxbury.	12
1926	Fairfield, Faith Janet.	Northampton	10
1927	Feener, Lester Conrad.	Gloucester.	12
1926	Feldman, Samuel Hyman.	Chelsea.	12
1927	Fenn, George Kingsley.	Beverly.	22
1927	Fletcher, Kenneth Steele.	Chicopee.	10
1927	Flynn, Thomas Francis.	Everett.	12
1926	Freedman, Joseph.	Fall River.	24
1926	French, Robert Weller.	Melrose.	10

1926	Gallison, Davis Thayer, Brookline	12	1926	*Simmonds, Frederick Joshua, Jamaica Plain	27
1927	Gallivan, John Joseph, So. Braintree	12	1926	Sleeper, Francis Harper, Worcester	10
1926	Garfin, Samuel William, Roxbury	10	1926	Smead, James Lawton, Springfield	11
1926	*Garneau, Benoit Wilfrid, Fall River	28	1926	Smith, Erdix Tenny, Springfield	30
1927	Gibbons, Joseph Francis, Roslindale	12	1926	Smith, Garnet Polydore, Fall River	11
1926	Goff, Almon Pliny, Hyannis	9	1927	Smith, Hollis Randall, Wellesley	10
1926	Goldberg, Hyman Bernard, Dorchester	12	1927	Sosman, Merrill Clary, Brookline	15
1927	Goldfarb, Daniel Charles, Boston	12	1926	Southworth, Franklin Chester, Framingham	11
1926	Goodale, Robert Lincoln, Boston	11	1926	Spector, Benjamin, Boston	8
1927	Goodman, Abram Robert, Quincy	26	1926	Splaine, Russell Leo, Watertown	12
1926	Goodwin, Harold Carl, Springfield (readmitted by the Censors)	18	1927	Stern, Louis Nathaniel, New Bedford	12
1926	Grand-Lienard, Robert James, Pittsfield	10	1927	Stevens, Harold Wentworth, Newtonville	11
1926	*Haynes, Helen Mildred, Brockton	27	1926	Swan, Channing Stearns, Boston	11
1926	Hoeffel, Gerald Norton, Boston	11	1926	Talamo, Haskell, Worcester	11
1927	*Hoffman, Walter Ralph, Lawrence	27	1926	Taylor, Joseph Vincent, Roxbury	11
1927	*Holland, Arthur Gregory, East Boston	27	1926	Toombs, Herbert Raymond, Lowell	12
1926	Howard, Louis Guilford, Boston	10	1927	Vail, John Insley Blair, Sandwich	17
1926	Hunt, Reid, Boston	25	1926	Webber, Charles Sumner, Weymouth	10
1927	Hunter, Francis Tenny, Boston	11	1926	*Weldman, Abraham, Cambridge	38
1927	*Hurewitz, Zilla, Cambridge	35	1927	*Weinrebe, Joseph, Brookline	27
1927	Israel, Cyril, Worcester	10	1927	Weiss, Soma, Boston	23
1926	Izzo, William Ralph, Tewksbury	12	1927	Wheeler, Daniel Redfield, Springfield	12
1927	Jepson, Paul Newton, Brookline	19	1927	Wilens, Gustav, Fall River	21
1926	Jones, Guy Walter Stanley, New Bedford	12	1927	Wilkinson, Marion Agnes Dinwoodie, Worcester	10
1927	Keene, Carroll Herbert, Chatham	10	1927	Williams, John Francis, Everett	12
1926	*Kleiman, Shmaria, Lawrence	34	1926	Woodman, Majorie, Roxbury	12
1926	*Knowles, James Robertson, Boston	4	New Fellows, 170. Readmitted by Censors, 1. Total, 171.		
1926	Kreplick, Morris Spellman, Lynn	12	*Indicates that the candidate's diploma was approved by the Committee on Medical Education and Medical Diplomas.		
1926	Lawler, William Spencer, Lowell	12	KEY TO MEDICAL COLLEGES		
1927	*LeBeau, Raoul Joseph, Brockton	2	1	University of Colorado School of Medicine.	
1927	Leonard, John Michael, Fall River	25	2	College of Physicians and Surgeons, Boston.	
1926	Levi, Alexander Abraham, No. Grafton	12	3	University of Michigan Medical School.	
1926	Levine, Abraham Morris, Mattapan	12	4	Chicago Medical School.	
1926	Lionberger, David Leo, Roslindale	11	5	Loyola University Medical Department.	
1927	*Listernick, Sidney Solomon, Everett	27	6	North Carolina Medical College.	
1927	*Logie, Arthur James, Westfield	7	7	Temple University Medical School.	
1926	Lombard, Herbert Luther, West Medford	29	8	University and Bellevue Hospital Medical College.	
1927	Lynch, Charles Leo, Norwood	12	9	University of Buffalo Medical College.	
1927	Lynch, Leo Joseph, Cambridge	10	10	Boston University School of Medicine.	
1927	Macaluso, Anthony, Dorchester	10	11	Harvard University Medical School.	
1927	Macdonald, Thomas Henry, Somerville	32	12	Tufts College Medical School.	
1927	*MacInchlan, Kenneth Long, Melrose	11	13	Long Island College Hospital.	
1927	*McKinney, Harold Napoleon, Roxbury	27	14	Woman's Medical College of Pennsylvania.	
1926	McLeod, Ralph Collingwood, Brockton	11	15	Johns Hopkins University Medical School.	
1927	McCarthy, Humphrey Leo, Lynn	12	16	Georgetown University School of Medicine.	
1927	Meledy, Joseph Aloysius, Boston	12	17	Columbia University, College of Physicians and Surgeons.	
1926	Meserve, Faith Lucena, Roxbury	10	18	Dartmouth Medical School.	
1926	Messer, Edward Crahan, Fall River	12	19	University of Pennsylvania School of Medicine.	
1927	*Millen, Maurice, Roxbury	27	20	Jefferson Medical College of Pennsylvania.	
1927	Miranda, Carlos Alberto de la, Fall River	37	21	Yale University School of Medicine.	
1927	Monroe, Robert Thornhill, Boston	3	22	University of Vermont College of Medicine.	
1926	*Muller, Joseph, Holden	33	23	Cornell University Medical School.	
1926	Munro, Rose Carleton, Worcester	1	24	McGill University Faculty of Medicine.	
1926	Nelson, William Wallace, New Bedford	11	25	University of Maryland School of Medicine and the College of Physicians and Surgeons.	
1927	Newman, Jacob Newton, Cambridge	12	26	University of Oklahoma School of Medicine.	
1927	*Nicholls, Melvin Henry, Melrose	27	27	Middlesex College of Medicine and Surgery.	
1926	Norton, James Joseph, Westfield	8	28	Laval University Medical Faculty, Quebec.	
1927	O'Connor, Cornelius Thomas, Cambridge	11	29	Bowdoin Medical School.	
1926	Pagliuca, Frank Anthony, Boston	12	30	Ohio State University College of Medicine.	
1926	Paris, William, Fall River	12	31	Northwestern University Medical School.	
1926	Peck, Eugene Curtis, Boston	11	32	Dalhousie University Faculty of Medicine.	
1926	Peckham, John Munroe, Fall River	12	33	Royal Hungarian University of Budapest.	
1927	Peirce, Lincoln Carret, Cambridge	12	34	University of Donskoy, Warsaw, Poland.	
1926	Philbrick, Maurice Swain, Leominster	11	35	Jurlew University, Jurjev, Russia.	
1926	Pinkus, Louis, Dorchester	12	36	Imperial University of St. Vladimira, Kiev, Russia.	
1927	*Purinton, Herbert Harmon, Chesterfield	29	37	University of Lisbon, Portugal.	
1927	Putnam, Tracy Jackson, Brookline	11	38	University of Vienna, Austria.	
1927	Queen, Hyman Samuel, New Bedford	12			
1926	Quincy, Josiah Edmund, Boston	31			
1926	Reilly, Elinor Fumivall, Quincy	10			
1927	Reynolds, John Andrew, Springfield	13			
1926	*Rice, Charles, Mattapan	27			
1926	Rooney, James Stewart, Boston Harbor	11			
1926	Rooney, Paul Neill Anthony, Roslindale	11			
1927	Ryan, Terence Cullen, Quincy	11			
1927	Sannella, Theodore, Somerville	12			
1927	Secord, Walter Newton, Watertown	19			
1926	Sheehan, Katharine Cecelia, Salem	12			

DEATHS REPORTED FROM JUNE 9, 1926, TO JUNE 8, 1927

Admitted	Name	Place of Death	Date of Death	Age
1891	†Achor, John Warren	Annisquam	Aug. 5, 1926	69
1877	†Bancroft, Winfred Baxter	Rutland	Sept. 14, 1926	76
1906	Bannon, John Hugh	Lawrence	May 27, 1927	50
1874	Bigelow, William Sturgis	Boston	Oct. 6, 1926	76
1903	Bowditch, Henry Ingersoll	Roxbury	June 8, 1926	51
1878	Bradford, Henry Withington	Wolfeboro, N. H.	Apr. 30, 1927	72
1884	†Brainerd, John Bliss	Middlebury, Vt.	Nov. 26, 1926	67
1880	Briggs, Edward Cornelius	Chestnut Hill (Newton)	Nov. 6, 1926	70
1868	†Brigham, Edwin Howard	Watertown	Sept. 14, 1926	85
1906	Brooks, Edith May	Newton	July 1, 1926	46
1878	Broughton, Henry White	Jamaica Plain	Jan. 15, 1927	75
1909	Brown, William John	Boston	July 17, 1926	63
1888	Brownrigg, John Sylvester	Roxbury	Sept. 21, 1926	69
1919	Brunick, Patrick Vincent	South Boston	Dec. 28, 1926	39
1922	Caldarone, Angelo	Lawrence	Jan. 29, 1927	32
1873	†Call, Norman	Waban	May 26, 1927	82
1888	Carroll, Thomas Francis	Lowell	July 10, 1926	62
1889	Clark, Leonard Brown	Waverley	Oct. 29, 1926	64
1914	Cutler, Myron Fred	Worcester	Feb. 24, 1927	47
1878	Daniels, Edwin Alfred	Boston	Mar. 13, 1927	74
1871	†Davenport, Bennett Franklin	Cambridge	June 3, 1927	82
1887	Dexter, Franklin	Boston	Jan. 18, 1927	69
1900	Dodge, Arthur Malcolm	Hampton Falls, N. H.	Oct. 17, 1926	64
1915	Donovan, Sylvester Edward	New Bedford	May 30, 1927	56
1912	Earl, George Henry	Newton	Mar. 3, 1927	68
1894	Ellison, George Washington	Spencer	Feb. 14, 1927	62
1880	Everett, Oliver Hurd	Worcester	Nov. 12, 1926	74
1919	Finck, Harry Paul	Brookline	Apr. 26, 1927	32
1913	Finnegan, Francis Augustine	Worcester	June 1, 1926	42
1903	Fitzpatrick, John Joseph	Charlestown	May 5, 1927	54
1899	Gallagher, William Howard	Boston	May 11, 1927	53
1883	†Gibbs, Locero Jackson	Chicopee Falls	July 12, 1926	81
1900	Golden, Lazarus	Roxbury	Nov. 6, 1926	55
1893	Grouard, John Shackford	Boston	May 31, 1927	60
1906	Hardwick, Sydney Curtis	Hingham	June 16, 1926	42
1884	Harrington, Harriet Louise	Dorchester	Nov. 22, 1926	63
1896	Hewes, Harry Fox	Boston	July 8, 1926	58
1900	Holmes, Harry Bigelow	Adams	Oct. 22, 1926	63
1885	†Hough, Garry de Neuville	Vineyard Haven	May 31, 1927	66
1876	†Huntress, Leonard	Lowell	June 3, 1927	78
1887	Ingraham, Lena Vaughn	Cambridge	July 16, 1926	63
1892	Jackson, Ralph Wentworth	Washington, D. C.	May 23, 1927	59
1893	Jones, William Marks	Lowell	Sept. 30, 1926	61
1883	Kellogg, Edward Brinley	Boston	Apr. 9, 1927	76
1907	Kent, Bradford	Dorchester	Apr. 8, 1927	50
1893	†Leach, Horace Morton	Rochdale	May 11, 1927	83
1905	Leary, Chrysostom, John	New Bedford	Feb. 8, 1927	58
1913	Leary, Patrick Frank	Turner's Falls	Jan. 21, 1927	59
1924	Lee, Grace Daniels Reed	Allston	Dec. 29, 1926	46
1900	Livingston, Ernest George	Lowell	Sept. 11, 1926	54
1889	†Lockhart, Joseph Smith	Worcester	Mar. 1, 1927	71
1907	Mathes, Roy Wentworth	Lynn	Dec. 14, 1926	88
1914	Meyer, Edward James	Somerville	Apr. 29, 1926	56
1919	McGrath, John Edward	Hudson	Nov. 25, 1926	54
1892	Ogden, Jay Bergen	Forest Hills Gardens, N. Y.	Apr. 13, 1927	58
1870	†Pillsbury, George Harlin	Lowell	Sept. 16, 1926	83
1905	Quessy, Alfred Henry	South Boston	Aug. 26, 1926	50
1873	Sabine, George Krans	Brookline	Mar. 21, 1927	79
1918	Saunders, Thomas Henry	Webster	Aug. 9, 1926	46
1910	Shanahan, Timothy Joseph	West Somerville	May 10, 1927	48
1914	Shields, Ellwood Emlen	Annisquam	Oct. 8, 1926	41
1917	Simon, Harold Francis	Winchester	July 6, 1926	45
1873	†Sprague, Rufus William	Boston	Oct. 1, 1926	79
1915	Stevens, William Russell	Boston	June 5, 1927	47
1879	Tuttle, George Thomas	Milton	Apr. 6, 1927	77
1865	†Webber, Samuel Gilbert	Newton	Dec. 5, 1926	88
1898	Wetherell, Arthur Bryant	Holyoke	Mar. 18, 1927	72
1884	Wheatley, Frank George	North Abington	June 14, 1926	74
1885	Whittaker, Clarence Wilder	Worcester	July 19, 1926	68
1911	Wood, Nelson Merwin	Boston	Mar. 13, 1927	60
1902	Woodruff, Richard Allen	Pittsfield	Oct. 13, 1926	62
1921	Wright, Mary	Roxbury	Jan. 13, 1927	37

Total number of deaths, 72.

†Indicates Retired Fellow.

OFFICERS OF THE MASSACHUSETTS MEDICAL SOCIETY FOR 1927-1928

ELECTED BY THE COUNCIL, JUNE 7, 1927

President: John M. Birnie, 14 Chestnut Street, Springfield.
Vice-President: Thomas J. O'Brien, 501 Beacon Street, Boston.
Secretary: Walter L. Burrage, 182 Walnut Street, Brookline.
Treasurer: Arthur K. Stone, Auburn Street, Framingham Center.

STANDING COMMITTEES FOR 1927-1928

ELECTED BY THE COUNCIL, JUNE 7, 1927

OF ARRANGEMENTS

W. T. S. Thorndike James Hitchcock E. P. Hayden
H. Q. Gallupe T. H. Lanman
F. H. Colby

ON PUBLICATIONS AND SCIENTIFIC PAPERS

E. W. Taylor R. B. Osgood F. T. Lord
R. M. Green A. C. Getchell

ON MEMBERSHIP AND FINANCE

D. N. Blakely Algernon Coolidge Samuel Crowell
Gilman Osgood Homer Gage

ON ETHICS AND DISCIPLINE

David Cheever W. D. Ruston S. F. McKeen
Kendall Emerson A. C. Smith

ON MEDICAL EDUCATION AND MEDICAL DIPLOMAS

J. F. Burnham A. G. Howard R. L. DeNormandie
H. P. Stevens C. H. Lawrence

ON STATE AND NATIONAL LEGISLATION

J. M. Birnie E. H. Stevens F. E. Jones
T. J. O'Brien Shields Warren

ON PUBLIC HEALTH

Victor Safford E. F. Cody R. I. Lee
T. F. Kenney F. G. Curtis

ON PUBLIC INSTRUCTION

A. W. Marsh W. P. Bowers W. H. Robey
R. I. Lee F. W. Snow Conrad Wesselhoeft
F. S. Hopkins W. J. Brickley

ON MALPRACTICE DEFENCE

F. G. Balch E. D. Gardner F. B. Sweet
F. H. Baker A. W. Allen

DELEGATES AND ALTERNATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

DELEGATES

F. B. Lund, Boston.
E. F. Cody, New Bedford.
H. G. Stetson, Greenfield.
C. E. Mongan, Somerville.
J. F. Burnham, Lawrence.
R. I. Lee, Boston.

ALTERNATES

W. H. Robey, Boston.
Kendall Emerson, Worcester.
L. A. Jones, Norfolk.
Gilman Osgood, Rockland.
A. R. Crandell, Taunton.
C. H. Lawrence, Boston.

PRESIDENTS OF DISTRICT MEDICAL SOCIETIES

VICE-PRESIDENTS (Ex-Officio)

Arranged according to seniority of fellowship in the Massachusetts Medical Society

E. A. Bates, Springfield.
A. W. Dudley, Cambridge.
E. P. Joslin, Boston.

J. E. Lamoureux, Lowell.
D. A. Bruce, Atlantic.
E. B. Hallett, Gloucester.
F. H. Washburn, Holden.
A. F. Lowell, Gardner.
T. E. Caulfield, Woburn.
P. E. Truesdale, Fall River.
M. H. A. Evans, Dorchester.
J. P. Shaw, Brockton.
F. H. Dunbar, Mansfield.
C. T. Cobb, Northampton.
A. M. Hubbell, Haverhill.
A. H. Ellis, Greenfield.
T. P. Hennelly, Pittsfield.
F. O. Cass, Provincetown.

COUNCILORS, 1927-1928

ELECTED BY THE DISTRICT MEDICAL SOCIETIES AT THEIR ANNUAL MEETINGS, APRIL 15 TO MAY 15, 1927

NOTE:—The initials M. N. C. following the name of a Councilor indicate that he is a member of the Nominating Committee. V. P. indicates that a member is a Councilor by virtue of his office as President of a district society and so Vice-President of the general society. C. indicates that he is chairman of a standing committee.

BARNSTABLE

F. O. Cass, Provincetown, V. P.
W. D. Kinney, Osterville, M. N. C.
E. S. Osborne, West Dennis.

BERKSHIRE

T. P. Hennelly, Pittsfield, V. P.
James Bunce, North Adams.
C. S. Chapin, Great Barrington, M. N. C.
Henry Colt, Pittsfield.
M. S. Eisner, Pittsfield.
A. P. Merrill, Pittsfield.

BRISTOL NORTH

F. H. Dunbar, Mansfield, V. P.
W. H. Allen, Mansfield.
W. O. Hewitt, Attleborough.
F. A. Hubbard, Taunton, M. N. C.

BRISTOL SOUTH

P. E. Truesdale, Fall River, V. P.
R. B. Butler, Fall River.
E. F. Cody, New Bedford, M. N. C.
A. B. Cushman, South Dartmouth.
S. E. Donovan, New Bedford.
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ORIGINAL ARTICLES

FIBROMATA OF THE INTESTINES

Report of a Case and Review of the Literature

BY HARRY C. CLIFTON, M.D., F.A.C.S., AND BENEDICT B. LANDRY, M.D.

FIBROMATA occur in every part of the digestive tract, in the mesentery and retroperitoneally, but are so rare that, until quite recently, they were considered as unique. We were led to a review of the subject of benign tumours of the intestines, with especial reference to fibroma,

because of contact with a case of intussusception of the ileum due to such a tumour. Two impressions derived from this review are first, that each type of benign tumour is of rare occurrence and secondly, the steadily rising number of reported cases of all types calls for a consid-

eration of their presence in patients presenting certain symptoms and conditions, notably intussusception in adults, and in obscure intestinal disorders.

The fibroma is not the rarest type of benign tumour of the intestine but among the rarest. Adenomata and lipomata are encountered more frequently and myomata, angiomas and a few other types, less so. The myoma is generally thought to be more common than the fibroma but without definitely ascertaining this fact it would seem, after looking over reports, not to be so and indeed Ewing states that myomata are less frequently found.

In attempting to tabulate all cases of fibroma of the intestines thus far reported we have, in common with others who have written on the subject of benign tumours, included under that heading the following: fibroma, myxoma, fibromyxoma and myxofibroma. There has been variance in classifying these together or separately, which would be expected because of the divergent views of different pathologists. Some, Ribbert for example, maintain the independence of each (fibroma and myxoma) as a tumour type, while others, among them Mallory⁴¹, state that myxoma and fibroma might well be considered as one type. A fibroma is a growth composed of cells derived from the fibroblast or connective-tissue cell. A myxoma is derived from similar cells which, however, have the primary quality of being able to secrete mucin. Hence, having a like primary cell-type derivation, we consider the difference between them to be of secondary importance and therefore include both types and obviously combination tumours of these under one head, fibroma.

In our tabulation we have not included other than tumours of the intestine. Undoubtedly some cases reported as fibroma of the mesentery concern tumours which arise from connective-tissue of the bowel-wall but grow between the leaves of the mesentery. However, some retroperitoneal tumours of similar type likewise grow between the leaves of the mesentery. Because of lack of uniformity in the reporting of this fact and on account of different signs and symptoms, it is felt they should be considered as a distinct class.

Combination tumours in which some of the tumour is made up of fibroblastic tissue and cells of another type such as adenoma or myoma have been excluded except in two instances. One of these was an adenofibroma, the case of Henriksen, which the pathologist stated to be "mostly fibroma." The other was a fibrolipoma, the case of Eliot²² which he states was composed practically entirely of fibrous tissue. Obviously, combination tumours should be classified under one head or the other according to the type of cells of which they are composed, and the determination of so classifying them should rest on

the type of tissue cell which is in greater abundance.

Dewis⁸, in 1906, was among the first to tabulate cases of benign tumours of the intestine and he was able at that time to find but four fibromata reported in the literature, which number was augmented by one of his own. A few instances were reported between Dewis' article and one by Kasemeyer²⁰, in 1908, which, though not dealing specifically with benign tumours but with intussusception, included six cases of fibroma. Kasemeyer has been credited with adding 8 cases of fibroma and in his article includes that number under the heading "fibroma," but King in a subsequent review excluded the case of Peeck because of insufficient evidence and the case of Enslin is considered as "rather a myofibroma." In 1911 Eliot and Corsecaden²¹, writing likewise on intussusception, included 10 cases of fibroma previously reported. One of these (Greig-Smith's) had been included in Kasemeyer's list and Eliot added 2 cases of his own, one a pure fibroma and the other a fibrolipoma, to which we have referred above.

The next article dealing with the subject was that of James and Sappington²⁴ in 1915. Individual reports had appeared from time to time. Among these were two cases of Watson and of Pantzer, which were shown by James and Sappington not to be fibromata as the title of their reports would indicate. At this time the total of reported fibromata was stated to be 24 and the case of James and Sappington brought it to 25. However, these authors included the two cases of Peeck and Enslin which, as said above, are excluded from our list for the reasons given. Also a case of adenofibroma among their number does not appear in our list.

King²⁹, in 1917, attempted to tabulate all types of benign tumour of the intestine reported up to that time and among his collection of cases were 16 fibromata. One of these, the case of Fenger, a fibroma of the mesentery, we have omitted. King at first failed to meet with the article by Kasemeyer and that of James and Sappington, so that his total number of fibromata was short of that which had actually been reported.

Meyer²⁷, in the *Annals of Surgery* in 1918, reported 2 cases of fibroma, one of which is among the 3 cases of this type of benign tumour mentioned by Rhodenburg⁴⁰ in 1919. The other case stated by Meyer to be a fibroma corresponds very closely in description to a case of benign tumour operated by Meyer but reported by Rhodenburg as a myoma with corroborative photo-micrographs. A case of Kammerer²⁸, also cited by Rhodenburg, agrees except as to the age of the patient, with a case reported by Kammerer himself, so that we have been led to believe that these two different reports concern one and the same case.

Since 1919 various instances of benign tumour

LIST OF CASES THUS FAR REPORTED

Name	Year	Sex	Age	Symptomatology or operative indication	Site of tumour	Intra or extra lumbar	Size	Intussusception present or absent	Path- ology of tumour	Resection and anastomosis	Operative procedure	Result
✓ Rubli	1891	F	19	—	Small intestine	—	Not given	Absent	Fibro- myxoma	Resection and anastomosis	—	Died
✓ Wagner	1894	F	40	Abdominal pain 14 days; then acute ileus.	Ileum	Intra	Not given	Present	Fibroma	Enterotomy ex- cision of tumour	—	Rec.
✓ Jansen	1896	F	35	Obscure digestive troubles; palpable tumour, left side of abdomen.	Descending colon	Intra	Fist	Absent	Fibroma	Resection of 13 in. of colon	—	Rec.
✓ Heurteaux	1896	F	32	Tenesmus; frequent and bloody stools. Tumour felt just above anal sphincter.	Rectum	Intra	Index finger	Absent	Fibroma	Ligation of pedicle	—	Rec.
✓ Heurteaux	1896	F	32	Tumour expressed through rectum during confinement.	Rectum	Intra	Egg	Absent	Fibroma	Ligation of pedicle	—	Rec.
✓ Greig-Smith	1896	F	31	Complete obstruction two years previous to operation. Recent intermittent colicky pain.	Ileum	Intra	Hen's egg	Present	Fibro- myxoma	Partial reduction Removal of tumour Resection	—	Rec.
✓ Steiner	1896	F	49	Repeated attacks of obstruc- tion. Onset—complete obstruc- tion.	Descending colon	Intra	Plum	Present	Myxoma	Reduction Enterotomy Removal of tumour	—	Rec.
✓ Heisig	1897	M	56	Abdominal pain, colic, anemia, loss of weight.	Jejunum	Intra	20x5 cm.	Present	Myxo- fibroma	Resection and anastomosis	—	Rec.
✓ Pitts	1901	F	32	Abdominal symptoms of 13 weeks' duration.	Caecum	Intra	—	Present	Fibroid growth	Reduction, remo- val of growth Fecal fistula	—	Died
Haasler	1902	M	35	Abdominal pain and meteor- ism for one year. Onset 7 weeks before more frequent pain. Hard mass on rectal examination.	Ileum	Intra	Plum	Present	Fibrous tumour at base of Meckel's Diverticulum	Reduction, resec- tion of Meckel's Diverticulum Artificial anus	—	Died
Bishop	1905	M	8	Tumour right lower quadrant.	Small intestine	Intra	Marrow-fat pea	Present	Fibroma	Enterostomy Reduction	—	Rec.
★ Royster	1905	M	42	Indigestion with occasional vomiting. For 6 months severe iliac pain. Palpable tumour— abdomen.	Sigmoid	Intra	—	Present	Fibroma	Reduction, enter- ostomy, removal of tumour	—	Rec.

LIST OF CASES THUS FAR REPORTED (Continued)

Name	Year	Sex	Age	Symptomatology or operative indication	Site of tumour	Intra or extra lumbar	Cherry with stem 4 or 5 in. long	Intussusception present or absent	Path- ology of tumour	Operative procedure	Result
Andrews	1906	M		Following fall from height, had typical symptoms of in- tussusception.	Ileum	Intra	Cherry with stem 4 or 5 in. long	Present	Fibro- papilloma	Resection of ileum	Died
Leuret	1907	F	45	Acute abdominal pain, vomit- ing.	Enteric	Intra	—	Present	Myxo- fibroma	Reduction, enter- ostomy Excision of tumour	Rec.
Delore	1908	M	42	5 months colic and vomiting. Sudden pain, vomiting, tu- mour palpable in abdomen.	Transverse colon	Intra	Small egg	Present	Fibro- myxoma	Reduction and resection	Rec.
Jowers	1908	M	15	Acute abdominal pain. Tu- mour right lower quadrant.	Ileum	Intra	Cherry	Present	Fibroma	Irreducible Resection 56 in. of small intestine End-to-end anas- tomosis	Rec.
Haerberlin	1908	F	66	Diarrhea for 2 months. Ab- dominal pain, vomiting, par- tial occlusion.	Intestine indefinite	Intra	—	Present	Fibroma	Resection	Rec.
Haerberlin	1908	F	58	Abdominal pain. Blood per rectum. Palpable tumour.	Ileo-caecal	Intra	—	Present	Fibroma	Irreducible enterostomy	Died
Lange	1910	M	50	Abdominal pain for 5 days. Obstruction.	Ileum	Intra	Walnut	Present	Fibroma	Resection Enterostomy	Died
Elliot	1911	F	67	Epigastric pain, vomiting, re- curring palpable tumour. Ap- parently of transverse colon. Recurring disappearing cene- mata.	Ileum	Intra	Lemon	Present	Fibroma	Partial reduction Resection	Rec.
Elliot	1911	M	40	Occasional abdominal cramps in left lower quadrant. Onset —sudden severe cramp-like pain in left lower quadrant. Tumour in right lower quad- rant. Brackish stools. Previ- ous blood per rectum.	Small intestine	Intra	English walnut	Present	Fibro- lipoma	Irreducible Resection 4 ft. small intestine	Rec.
Legue	1912	F	30	Palpable abdominal tumour.	Ileo-caecal region	Extra	—	Absent	Fibroma	Resection and anastomosis	Rec.

LIST OF CASES THUS FAR REPORTED (Continued)

Name	Year	Sex	Age	Symptomatology or operative indication	Site of tumour	Intra or extra luminal	Size	Intussusception present or absent	Path- ology of tumour	Operative procedure	Result
Faure et Deplas	1913	F	23	Palpable abdominal tumour, thought to be of uterus.	Caecum	Extra	14x11x8 cm. (Infant's head)	Absent	Fibroma	Resection of 10 in. ileum, part of caecum and lower colon—lateral anastomosis	Rec.
Stetter	1915	M	51	Symptoms of intestinal occlu- sion.	Intestine (indefinite)	Intra	English walnut	Present	Fibroma	Reduction—resec- tion of intestine with tumour	Rec.
Means and Forman	1915	F	37	Colicky pains, obstipation.	Ileum	Intra	3.5x4x3 cm.	Present	Fibroma	Reduction, enter- otomy	Rec.
Kammerer	1917	M	40	Pain in abdomen, meteorism for 1½ years. Anemia, loss of weight. Pain of colic type getting more severe.	Ileum	Intra	10x6 cm.	Present	Fibroma	Partial reduction Resection 3½ ft. of small intestine End-to-side anastomosis	Rec.
King	1917	F	38	Movable tumour, left upper quadrant of abdomen—noted for two months. Loose stools.	Jejunum	Extra	Fist	Absent	Fibroma	Resection of tumour Wound of intestine sutured	Rec.
Mayo Clinic King		M	17	Tumour right iliac fossa 2 months. No bowel disorder.	Ascending colon	Extra	—	Absent	Fibroma	Resection 8 in. of ileum, caecum and colon	Rec.
Mayo Clinic King		F	30	Blood in stool for one year. Rectal tumour.	Rectum	Intra	Large polypoid	Absent	Fibroma	Removal of tumour	Rec.
Meyer	1918	M	52	Repeated attacks of obstruc- tion.	Ileum	Intra	6x4 cm.	Present	Fibroma	Resection of gut Anastomosis	Died 5 wks. later pneumonia
Flynn (by Rhodenburg)		F	25	Intestinal hemorrhage. Pal- pable rectal tumour.	Rectum	Intra	3x1 cm.	Absent	Fibroma	Removal of tumour	Rec.
Henrichsen	1918	F	35	Diarrhea, symptoms of ileus.	Caecum	Intra	—	Present	Fibroma	Resection of cae- cum, ileum and part of ascending colon	Rec.
Bevan	1919	M	35	Hemorrhage for one year or more. Obstruction. Palpable abdominal tumour.	Splenic flexure of colon	Intra	Large	Present	Fibroma	Enterotomy resection of tumour Reduction	Rec.

LIST OF CASES THUS FAR REPORTED (Concluded)

Name	Year	Sex	Age	Symptomatology or operative indication	Site of tumour	Intra or extra luminal	Size	Intussusception present or absent	Path- ology of tumour	Operative procedure	Result
Willis	1920	F	8	Abdominal pain. Tumour (abdominal).	Ileum	Intra	2 cm. in diameter	Present	Fibroma	Irreducible Resection of 18 in. of small intestine	Died
Jefferson	1920	F	24	3 attacks of pain in right iliac fossa in 6 months. Movable mass in right lower quadrant.	Ileo-caecal valve	Intra	Hen's egg	Present (partial invagination)	Fibroma	Resection of ileum and ileo caecal valve—End-to-end anastomosis	Rec.
Biggs	1920	M	49	Blood in stool, obstruction.	Ileum	Intra	3.5x3 cm.	Present	Myxoma (?)	Resection Anastomosis	Rec.
DeePias et Flandrin	1924	M	39	Colicky pain. Diarrhea, dysentery.	Jejunum	Intra	7x5x3	Present	Fibro-myxoma	Resection	Rec.
Stewart (by Liu)	1925	F	67	Chronic intestinal obstruction c nausea and vomiting for 10 months. Tumour R. L. Q. 7 months. Loss of weight.	Ileum	Intra	6x3 cm.	Present	Myxo-fibroma	Resection of ileum and caecum	Died
D'Agata	1925	F	20	Vague abdominal pain few months, vomiting. Tumour right iliac fossa.	Ileum	Intra	A large nut	Present	Fibro-myxoma	Resection of 10 in. of ileum Plication of caecum	Rec.
Clifton and Landry	1926	M	48	Colicky pain, nausea. Partial obstruction. Several attacks. Tumour left lower abdomen.	Ileum	Intra	3.5 cm. in diameter	Present	Fibroma	Resection of 10 in. of ileum End-to-end anastomosis	Rec.
Duckworth	1866	F	43	<i>Autopsy</i> Died c symptoms of pyemia. No symptoms during life referable to tumour.	Ileum	Intra	Four tumours. One size of large walnut. Three, size of "horse" beans.	Absent	Fibroma (Only one tumour examined)		
Sandberg Och Key-Aberg	1889	M	60	Died with symptoms of ileus.	Small intestine	Intra	Walnut	Present	Papillomatous fibroma		
Gossage	1895	M	21	Abdominal pain, tarry stools just before death.	Ileum	Extra	2½ x 1¼ in.	Present	Fibro-myxoma		
Vaccari	1903	Not given			Duodenum	Intra	Large nut 1.8x1.6x1.5 cm.	Not definite	Fibroma		
Dewis	1906	F	64	Abdominal pain, vomiting, constipation increasing.	Ileum	Intra	3.5x2.2x2.5 cm.	Present	Fibroma		

of the intestines have been reported and the sum-total of such tumours of all types is gradually mounting. All told, up to the present writing, we have collected 45 cases of fibroma of the intestine, which seem to us worthy of being tabulated as a group. Of these 45 cases, 40 were encountered at operation, and five at autopsy.

The pathological examination of the tumours was made by Dr. Henry C. Russ of St. Francis' Hospital and by Dr. F. B. Mallory of the Boston City Hospital.

CASE HISTORY

Hospital No. 4291—Manchester Memorial Hospital. A. G., Swedish male, age 48. Painter. He was born in Sweden and has resided in this country 18 years. He first entered the Hospital December 4, 1924. His chief complaints were sharp, colicky pains in the epigastrium, slight nausea and occasional vomiting, distention and gaseous eructation.

Illness—About six weeks ago the patient states that "he felt as though there was a lot of gas on his stomach." He was constipated and had a few colicky pains in the abdomen. His appetite has been good. He has noticed a metallic taste at times, generally in the morning. The taking of castor oil would give him a feeling of well-being for a few days, when the above enumerated symptoms would recur. The pain and constipation have seemed to grow worse. Straining at stool or coughing causes pain and a "feeling of weakness" in the left lower abdomen.

History—Family history and marital history are irrelevant. Also genito-urinary and nervous systems.

Physical Examination—Patient looks pale and exhausted. Head, neck, respiratory and cardio-vascular systems show nothing abnormal other than a rather marked pyorrhea and a coated but moist tongue.

Abdomen—There is considerable distention and tympanites with some rigidity of the abdomen, although this latter is not marked. There is slight tenderness about the umbilicus and considerable pain on pressure at this point. When the patient is seized with pain of a colicky nature, a hard lump may be felt at the region of the umbilicus. With disappearance of the pain, this lump likewise disappears and is not again felt until the pain recurs. No other masses felt; no evidence of fluid. Liver and spleen not palpable. Red blood count 4,384,000. Hemoglobin 85%. White blood count 13,800. Coagulation time 4 minutes.

Diagnosis—Partial intestinal obstruction.

Treatment—Bed, high colonic irrigations, flaxseed poultices to abdomen; observation.

The patient remained in the Hospital until December 23, 1924, a stay of 19 days. During the first part of his stay vomiting occurred, the vomitus being at first greenish, fluid material and later yellowish, but at no time faeculent. His bowels were moving satisfactorily three days after admission, and the colicky pain accompanied by the lump near the umbilicus gradually disappeared. His temperature and pulse remained normal during his entire stay.

The patient was seen by a surgical consultant, who concurred with the above diagnosis.

An X-ray was taken and the report is as follows:

"Shows the stomach normal in size and outline, well up in abdomen, its pyloric end distinctly inclined to spasticity and not well visualized; completely filled throughout the series. The duodenal cap presents no filling defect but almost immediately the small intestinal folds begin to show dilatation, particularly the lower jejunum and ileum. After six hours the meal lies chiefly in the considerably enlarged coils of small intestine with moderate residue in the stomach. Appendix remains filled and is

pinched apparently at its base. After 24 hours the meal is distributed in the large intestine with a moderate residue in the dilated small intestinal coils."

Summary of Roentgenologist, Dr. Douglas Roberts—"Findings point to a partial obstruction of the small intestine well downward towards its junction with the caecum, resulting in marked dilatation of its coils, probably the result of an old inflammatory process in the appendix with resulting bands or adhesions."

Despite the obvious diagnosis both clinically and by X-ray, the patient for some undetermined reason did not come to operation at this time.

SECOND ADMISSION

February 2, 1925. His chief complaints at this time were abdominal pain, nausea and vomiting.

Present Illness—Following his recent discharge from the hospital, he remained comfortable for a time on a restricted diet, but when he commenced to eat a varied diet, his trouble became worse than before, the pains increasing in severity and frequency. His abdomen becomes distended, making him quite uncomfortable. For the past few days he has been much worse and has vomited several times. Red blood count 4,160,000. Hemoglobin 70%. White blood count 18,000. Polymorphs 73%. Small lymphocytes 21%. Large lymphocytes 4% and transitional cells 2%. Urine negative.

The day after admission, he was seen by Dr. Clifton in consultation. At this time there was a definitely palpable mass in the lower left side of the abdomen, which was movable, tender and hard. There was tenderness also over the entire left side of the abdomen, more marked in the left upper quadrant. Distention was moderate. A diagnosis of carcinoma of the sigmoid was made and operation urged. A barium enema was given, but the X-ray findings were inconclusive.

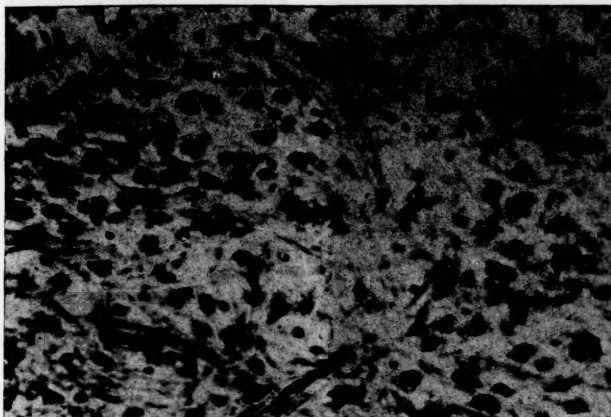
February 4, 1925—Operation by Dr. Clifton. A 6 cm. lower left rectus, muscle-splitting incision was made, the abdomen opened and the sigmoid and rectum explored and found normal. On further exploration a mass was palpated, found to be movable and



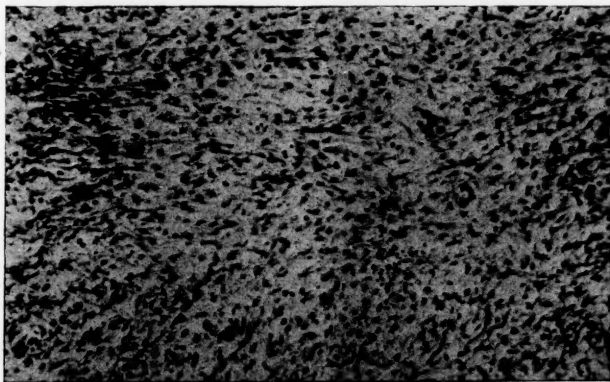
delivered into the wound. The mass consisted of intussuscepted ileum, about five to six inches in length. The intussusception was reduced by pulsion

and gentle traction manoeuvring, after which a tumour mass was felt inside the lumen of the bowel. No enlarged glands were found. The ileum proximal to the tumour within the bowel lumen was very much thickened and oedematous. Because of this condition of the bowel wall and the uncertainty regarding the viability of a small segment of ileum, a resec-

his bowels functioned well, aided by enemata and the insertion of a rectal tube. On the ninth day post-operative he had an unexplained rise of temperature to 101°, although the pulse remained normal. On the following day the temperature dropped to normal and remained so until the 16th day after operation, when he had a chill and an abrupt rise to 105 with



Magnification 500. The fibroglia fibrils are well shown. In the centre there is a mitotic figure—an endothelial leukocyte undergoing division.



Magnification 200. The tumor is infiltrated with lymphocytes and endothelial leukocytes.

tion was decided upon. About 10 inches of bowel, including the tumour, were removed and the severed bowel repaired by an end-to-end anastomosis. The abdominal wound was closed in layers. The operation lasted approximately one and one-half hours. The patient was returned to bed in fair condition and modified shock treatment was instituted.

Post-Operative Course—Between this time and the 14th of February, nine days after operation, the condition of the patient steadily improved and his convalescence was as satisfactory as one would look for. He expelled gas and a small amount of faecal matter on the second post-operative day and from then on

a correspondingly rapid rise in pulse rate to 150-160. His condition was precarious and remained so for several days. During this time he complained of pain and tenderness in the region of the gall-bladder. On the 23rd of February, the 19th day post-operative and the third after the onset of this complication, the temperature dropped to below normal, gradually assumed a normal level and from then on remained so. At this time the gall-bladder was definitely palpable and considerably enlarged. Operation was contemplated, but in view of his recent operation, it was decided to defer it now that his temperature had fallen. He steadily improved in every way until

the time of discharge, 31 days following his operation.

We were last in communication with him three months ago, in February, 1927, two years after operation, when he stated that he felt well and entirely free of his previous symptoms.

In our series of collected cases there were 32 fibromata, 6 fibromyomata, 3 myxofibromata, 2 myxomata and one fibrolipoma and one adenofibroma, both of these latter being included because the tumour mass in each case was mainly composed of fibrous tissue.

Their locations were as follows:

Small intestine		Colon	
Duodenum	1	Caecum	3
Jejunum	3	Ascending	1
Ileum	18	Transverse	2
Ileo-caecal	3	Descending	2
		Sigmoid	1
Enteric	7	Rectum	4
(Part of bowel not stated)			

Total—45

SEX-AGE

There was no marked greater frequency in one sex compared to the other, the females numbering 25, males 20, and in one case the sex could not be determined. The youngest patients were that of Willis and that of Royster, aged 8, the oldest that of Heurteaux, aged 66. The average age of 39 of the operated cases was 39.3 years.

SIZE OF TUMOURS

This varies. Those tumours occurring within the lumen give signs and symptoms before they have attained any large growth and of course those in the small intestine give symptoms sooner than those in the large. Intraluminal tumours vary in size from a marrow-fat pea up to that of a hen's egg. The extraluminal type, at times, grow to considerable dimensions, as the case of Faure and Deplas¹⁹, in which the tumor attained about the size of an infant's head. The usual size of intraluminal fibromata of the small bowel is that of a plum up to that of a small lemon.

ORIGIN

Universal agreement as to whence these tumours arise is lacking. Heurteaux² maintained that the intra-luminal fibromata arise from the sub-mucous connective-tissue and the extraluminal from the subserous connective-tissue. Gross pathologic examination of tumours of the intraluminal group often bears out this opinion as to their origin, in that their pedicles, whether sessile or pedunculated, are covered by mucous membrane which also may be seen extending upward for varying distances over the body of the tumour. Some maintain that the theory of inclusion accounts for their origin and this notion is supported by the finding of such com-

bination tumours as the osteofibromata, a case of which was recently reported by Auvray. Their origin from periarterial connective tissue is yet another source held by some.

Of the total number of tumours, 40 were encountered at operation and 5 at autopsy. Of those operated, 31 recovered and 9 died. Thirteen were intraluminal, 5 extraluminal and in one case this relationship of the tumour to the bowel wall was not determined. Of the intraluminal, 4 were of the rectum and 4 were found at autopsy. Regarding the cases in the rectum, they may be dispensed with briefly by stating that in all cases the tumor was either seen or felt on rectal examination and removed, with recovery in every case. The extraluminal tumours will not be considered.

Of the remaining 31 operative cases of intraluminal tumour, intussusception was present in 29, partial invagination in one (Jefferson's) and in the other, operation was done because of palpable tumour occurring in the colon (Jansen). The majority of these tumors were of the small intestines and mostly in the ileum. There were eight deaths among the number of operated cases, one of which (Meyer) died of pneumonia 5 weeks following operation. If we exclude this, as a death not connected with the condition for which operation was done, the mortality is found to be approximately 27.5%, which figure agrees almost exactly with that obtained by James and Sappington in an analysis of 25 similar cases, most of which were fibromata.

Since we have been more interested in the intraluminal fibromata of the small intestine complicated by intussusception, the remarks that follow have mainly to do with this type, but are as well applicable to intraluminal tumours of whatever benign type occurring in both the small intestine and colon.

Intraluminal fibromata are extremely latent. In no case in the series was such a tumour of the small gut palpated previous to operation and in only 2 instances of those in the colon. Those in the small intestine are almost invariably discovered only when surgical intervention is needed for the intussusception, by which they practically always assert themselves. Many of the patients have symptoms of a like nature extending over periods of months and years; some have had attacks of partial intestinal obstruction and less often, complete obstruction. Many present a picture in some ways typical of benign tumours of the bowel, especially the small bowel. The symptoms comprising this picture are (1) pain of an intermittent colicky nature accompanied by nausea, (2) the pain often starting from the same place and remaining fairly well localized. A third important part of the picture is the sudden relief experienced from the pain and nausea. At times, as in our case, a mass may be felt over the area to which the pain is referred, varying in the extent of its pal-

pability with the intermittency of the attacks of colicky pain. These attacks of pain so often accompanied by nausea, are probably caused by a marked and localized spasm of the bowel proximal to the tumour, to a partial invagination or even an intussusception, the first of which, ceasing, and the latter two conditions being spontaneously reduced, afford sudden relief.

Because of the frequency in the small bowel, pain in the right side of the abdomen is common with benign tumours. For this reason appendicitis is at times diagnosed and since the symptoms when first starting are of varying severity and of a mild indigestive nature, it is not surprising that there should be this confusion.

The nausea lasts as long as the pain and with the relief of the pain, the nausea passes. In a study of fibromyomata of the bowel, Boidin and de Gennes have stressed the frequency with which nausea occurs with this type of benign tumour also. Vomiting does not figure prominently in the picture until the invagination or intussusception is marked. Then, with the development of intestinal obstruction vomiting, of course, occurs, but it is often preceded by a longer period of nausea than is usual in obstructive conditions due to other causes.

Diarrhea and constipation are frequent symptoms, often alternating. The diarrhea at times is marked. Colitis, hemorrhagic colitis and dysentery have been confused with the true state of conditions.

Loss of weight, though not common, occurs and is in some patients pronounced. It is more apt to happen with those having frequent or marked diarrhea or hemorrhages of varying degrees, with resultant anemia.

Bleeding varies from small amounts discoverable by tests for occult blood in the feces to amounts so considerable as to greatly incapacitate the patient and even endanger life. Boidin and de Gennes have reported a case of fibromyoma of the small intestine in which death was due to massive hemorrhage. There may be bright red blood in the stools or these may be tarry and "blackish." In Bevan's case, for example, the blood recurred at frequent intervals over a long period and because of the accompanying diarrhea, hemorrhagic colitis was diagnosed. When intussusception occurs, blood is found in some cases, but it is a variable finding and does not by any means form as classical a part of the picture in adults as in the case of children. The tumors, when examined post-mortem or after operation, are, as a rule, quite vascular and often the mucosa covering them is eroded and ulcerated. However, at times none of these changes is found though hemorrhage has been marked.

THE X-RAY

Because so many of these patients have acute conditions necessitating immediate surgical aid,

X-ray studies have been made in but a few cases, with little help. However, our case proves that in any patient with similar clinical history and X-ray findings, the presence of an intraluminal tumour of the small bowel of benign type should be seriously considered, if not the first diagnosis to be made.

RELATION TO INTUSSUSCEPTION

These tumours, as mentioned above, almost always assert themselves by being concerned in the production of intussusception. Although no entirely satisfactory explanation of the causation or mechanism of intussusception has as yet been adduced, it is certain that it may come about in more than one way, namely:—

- (1) Perverted peristalsis.
- (2) Paralytic conditions of the bowel, allowing one part to prolapse into the other.
- (3) The reaction of the intestine to a foreign body or its equivalent.

Thus far, this latter is the most satisfactory explanation of intussusception in the majority of cases in adults and indeed, as recent evidence indicates, those occurring in children. Perverted peristalsis must be at least assumed as a cause, otherwise the unusual intussusceptions of retrograde type occurring in life, and observed forming and spontaneously reducing themselves on the operating table and in post-mortem examination, can probably not be explained.

Without doubt the frequent finding of benign tumours in cases of intussusception in the adult cannot help but lead us to associate one with the other as cause and effect. The intestine proximal to the tumour is often found greatly thickened, evidence of its efforts to propel the partially obstructing or stenosing tumour onward.

As Willis³³ suggests, the bowel attempts to expel the tumour as it would a bolus of food. The tumour being fixed to the bowel wall itself, however, its efforts to do so are in vain. At times the attempts of the intestine are stronger than at others and will result in pain due to intestinal spasm, and at times in pain of a colicky type with nausea, which probably comes from a partial invagination. What probably happens in these patients with benign tumour of the bowel, having this type of pain and the nausea which accompanies it and then sudden relief, has been well visualized by Biggs³⁴, whom we take the liberty of quoting. "Concerning the cause and symptoms of benign tumours of the small bowel, the first manifestation will probably be slight obturation followed later by chronic stenosis and perhaps recurring intussusception. Early symptoms may be absent or slight and the patient may be suddenly stricken. More often the symptoms are progressive and vary with the location of the growth. The higher the situation of the tumour in the bowel, the later will be the development of symptoms because of the fluid state of the intestinal content."

After efforts to expel the tumour body, intussusception is brought about, the tumour, as it were, asserting itself finally by this drastic means. We might try to visualize the sequence of events, assuming that surgical intervention was not resorted to. Finding useless its efforts to propel the body forward, that part of the intestine to which the tumour is attached is encompassed by the intestine above and, left to itself, there would be an attempt to expel this combined mass by rectum. Not a few instances of intussuscepted bowel being passed in this manner are on record and in some, recovery has occurred.

Recently there has been evidence presented to support the theory of intestinal reaction to a foreign body or its equivalent by Perrin and Lindsay³⁷. In a study of 400 cases of intussusception in children they found the lymphoid tissue of the ileum at its maximum development towards the end of the first year of life, when such a large proportion of intussusceptions occur in childhood. In the colon they found the folds of mucosa studded with numerous small lymph follicles, which, with the changes in feeding, consequent change in bacterial flora, and digestive upsets that occur commonly towards the end of the first year, became inflamed and swollen, acting as virtual foreign bodies. These writers state that the determining factor in the production of intussusception in children is the presence of the equivalent of a foreign body. They summarize as follows:—"There is produced, as a result of the swollen lymph follicles, an increased projection of the folds and a loss of elasticity of the oedematous mucosa, simulating with more subtle mimicry, to the excited segment of bowel, a foreign body."

Also Barnard's explanation of intussusception due to a Meckel's diverticulum, according to Perrin and Lindsay, agrees with this conception for he holds "that there is a prolapse of the mucous lining of the diverticulum into the lumen of the bowel."

Kasemeyer, in 284 cases of intussusceptions in adults, found that in 208, tumours were present. In the remaining 76, appendices or diverticula were found. Eliot and Corseaden, in reviewing 300 cases of intussusception occurring in adults, found 100 associated with new growths, 60 of which were benign. Some of their cases were due to true foreign bodies such as a date, a nail and ascaris worms and some of the other equivalents, according to Perrin and Lindsay, of foreign bodies such as dysenteric and tuberculous ulcers. Several occurred in patients, the victims of recent typhoid, in which condition the swelling and enlargement of the so-called "Peyer's patches" forms a characteristic pathologic finding.

Hence, of the ways by which intussusception may be brought about, its causation by a foreign body or its equivalent, such as fibromata or other

benign tumours, seems to explain the largest number of cases in adults and in children. So nearly axiomatic is this that the conclusion must be drawn that a foreign body or its equivalent, most likely a benign tumour, should be sought for in any case of intussusception occurring in the adult.

OPERATIVE PROCEDURES

Concerning a choice of operative procedure for dealing with cases of fibromata and benign tumour complicated by intussusception, much depends on the finding in the individual case. Sometimes reduction of the intussusception and enterotomy will be sufficient. This is perhaps the ideal way, but often, because of the thickening, oedema and inflammation of the bowel and doubt as to its viability if replaced within the abdomen, this course cannot be followed. In one case in our series (Bevan³²) an enterotomy was done and the tumour removed, following which the intussusception was reduced. Because of the reasons given above, resection will be more commonly indicated. The tumours when sectioned are often inflamed and infiltrated with leukocytes and at times enlarged glands are found in the mesentery. In any case where there is doubt as to the benignity of the tumour or when enlarged glands are present, one is especially apt to be doubtful and resection is the only rational procedure. However, bearing in mind that benign tumours of the small bowel outnumber malignant tumours by over 2 to 1 and enlarged glands being absent, it is equally rational, if the intussusception is reducible, to do a simple enterotomy and then if gross characteristics of the tumour further indicate it as benign, to excise the tumour and pedicle. Often the intussusception is irreducible and there is no recourse except to resection. The intussuscepted bowel containing the tumour is removed and then some form of anastomosis performed to re-establish the intestinal channel.

SUMMARY

A case of fibroma of the ileum associated with intussusception is reported and an attempt made to tabulate all cases of fibromata of the intestines thus far reported.

Forty-five such cases were found in the literature, of which forty were encountered at operation and five at autopsy. The majority were found in the small intestines.

These tumours most commonly assert themselves by bringing about intussusception. Evidence is produced to show that intussusception is brought about by the reaction of the bowel to what is virtually a foreign body.

Methods of operation in dealing with fibromata are mentioned.

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INVESTIGATION OF CASES OF UNIDENTIFIED ILLNESS IN HAVERHILL, MASSACHUSETTS*

BY LYMAN A. JONES, M.D., AND HERBERT L. LOMBARD, M.D.

ABOUT January 22, 1926, certain cases of illness in Haverhill, for which hospital admission was sought, were brought to the attention of the local Board of Health. The question arose as to whether they were influenza, scarlet fever, or some other communicable infection. Investigation disclosed numerous other instances of a similar affection.

The State Department of Public Health and Dr. Edwin H. Place of the South Department of the Boston City Hospital were immediately consulted. A thorough clinical study was made by Dr. Place and his collaborators and an epidemiological survey by the State Department of Public Health. Dr. Place published in the BOSTON MEDICAL AND SURGICAL JOURNAL dated February 18, 1926, a preliminary report of his study of the disease, which he named "Erythema Arthriticum Epidemicum."

Parker and Hudson carried out an exhaustive examination of the organisms which were isolated from the blood of patients stricken in the epidemic and reported it in the *American Journal of Pathology*, September, 1926. As the epidemiological and bacteriological findings do not wholly agree in that the one traces the outbreak to milk while the other finds that the organism (*Haverhillia multiformis*) does not flourish in milk, it is considered desirable to publish the result of the epidemiological research in detail.

Eighty-nine cases were investigated, eleven of which were discarded as not belonging to this group. The seventy-eight cases which remained were distributed in thirty-seven families. Sixteen families had only one case, several had two, three, or four, while one family had ten.

The malady was limited largely to a certain section of the city in the vicinity of River, Washington and adjoining cross streets. The cases not living in this vicinity either worked or visited there.

*From the Massachusetts Department of Public Health.

Thirty-three males and forty-five females were affected.

The age distribution was as follows:

Age	All cases	First case in family
0-5 years	15	4
6-10 "	11	4
11-15 "	14	3
15-20 "	6	6
21-30 "	7	3
31-40 "	13	7
41 over	9	7
Unknown	3	3
Total	78	37

The onset of the illness was characterized generally by malaise, headache, and fever ranging from 100° to 104°. Occasionally chills were present early in the sickness, followed frequently by vomiting and nosebleed. It was noted that in a few cases sore throat developed early but in many instances an interval of several days elapsed before it occurred. Whenever sore throat was present, it lasted for many days.

By the third or fourth day, in the majority of instances, a rash appeared, in some cases somewhat similar to that of measles, and in others like that of scarlet fever. This rash was mostly limited to the forearms, though sometimes it was observed reaching to and onto the shoulders and the legs below the knees. In some cases there was a fine bran-like peeling. In one or two instances the lesion involved the face also. Ordinarily there was no eruption on the trunk.

After several days joint pains became prominent, often of considerable intensity, usually without heat or redness. Sometimes the joint pains were accompanied by swelling or even by evidence of fluid.

The usual course of the illness seemed to be comprised within ten days or two weeks, though sometimes relapses occurred and dragged it out to four or five weeks.

All cases developed between January 2 and January 29, 1926 (Chart 1).

TABLE I
SYMPTOMS PRESENT

Symptoms	Number	Per cent
Joint	69	88
Fever	69	88
Rash	65	83
Vomiting	54	69
Headache	37	47
Chill	21	27
Sore throat	18	23
Cough	17	22
Malaise	16	20
Backache	13	17
Nosebleed	6	8
Pain in abdomen	4	5
Desquamation	2	2
Herpes	2	2
Pain in neck	1	1
Toothache	1	1
Earache	1	1
Nausea without vomiting	1	1
Relapse	Several	

NOTE.—It is probable that in many cases the minor symptoms were so overshadowed by the more prominent ones that they were not reported to the investigators.

The milk supply of the thirty-seven families, wherein the seventy-eight cases developed, was derived from thirteen sources. A number of families had two supplies and were uncertain when they used each. There were forty-six cases in seventeen families regularly using milk furnished by milk-man "A" and twenty-eight cases in sixteen families who occasionally used his milk. Four families with a total of four cases denied using this man's milk. The four cases had their onset in the latter part of the outbreak, the earliest one occurring two weeks after the first case. Two of these four patients visited at homes of patients sick with the disease one or two days prior to their illness. The remaining two gave no history of known contact, but as both lived in neighborhoods where a number of cases existed, contact was possible.

As over 90 per cent of the sick individuals used "A's" milk, suspicion was directed to it. A list of his customers was obtained and it was found that he delivered twenty quarts of milk at the homes of thirteen families and about sixty quarts at four stores. Illness occurred in eight of the families supplied in their homes by "A," as well as in twenty-five families who bought nearly all or a part of their milk at the stores supplied by him. In the neighborhood of the store selling the largest amount of this milk was found the greatest concentration of cases. Of the total number of seventy-eight cases, seventy-four used "A's" milk to a greater or less extent.

An investigation at "A's" dairy and at two other dairies from which he received milk dis-

closed no evidence of illness in the families concerned, nor did an examination of the dairy animals by a veterinarian of the Department disclose any evidence of sickness among the cattle. Pasteurization of this milk was begun on January 29.

The water supply of this locality was the same as that for the rest of the city where there were no cases.

Raw foods were used in seven families having twenty-three cases and not used in twenty-three families having forty-three cases. Records could not be obtained in the remaining seven families having twelve cases.

There was nothing distinctive in the environment of the patients. Twenty per cent lived in good homes, 65 per cent lived in fair homes, and 14 per cent lived in poor homes.

While there were multiple cases in many households, the illness gave very little evidence of being contagious, for other households of varying numbers developed but a single case. Among first cases in families six gave histories of contact with other cases, twenty-three denied any contact and eight did not know. In families having multiple cases the interval between the first case and subsequent ones was as follows:

Interval	Cases	Interval	Cases
Less than one day	4	Nine days	1
One day	8	Ten days	2
Two days	3	Eleven days	0
Three days	4	Twelve days	1*
Four days	7	Thirteen days	1
Five days	2	Fourteen days	0
Six days	1	Fifteen days	2
Seven days	1	Sixteen days	0
Eight days	2	Seventeen days	2

In connection with the Haverhill outbreak may be mentioned a group of cases presenting similar symptoms which occurred at the Walter E. Fernald State School, Waverley, Massachusetts. These were sixteen in number, nine males and seven females. The cases occurred among both inmates and employees of the institution. With the exception of the three-year-old son of the assistant superintendent and one eight-year-old inmate, all were individuals over sixteen years.

The symptoms were similar to those at Haverhill, but rash and arthritis were not as prominent, and sore throat often appeared at an earlier period. The staff of the institution did not name the condition. They reported that it was unlike anything previously experienced there. The symptoms observed were as follows:

*This case returned home to nurse his sick father on the fourth day of his father's sickness. Twelve days later he himself became ill.

TABLE II
SYMPTOMS PRESENT

Symptoms	Number	Per cent
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Malaise	16	100
Headache	16	100
Fever	14	88
Sore throat	12	75
Vomiting	8	50
Backache	8	50
Cough	7	44
Joints	6	38
Pain in neck	4	25
Muscle pains	4	25
Prostration	4	25
Rash	3	18
Sinusitis	2	12
Nosebleed	1	6
Pains in bones, profound	1	6

The first case occurred on November 27, 1925, and the last one on January 31, 1926. Ten of the sixteen cases occurred between January 11

and 21, 1926. These cases were well distributed in the different buildings at the institution, which housed about 1600 people.

The water supply is the same as that of the city of Waltham, where no cases are known to have occurred.

The milk is produced on the farm.

Raw foods are served in the institution.

CONCLUSIONS

1. The clinical picture of the disease was one of an acute toxic condition, followed by a blotchy somewhat morbilliform eruption with a tendency to petechiae, and later by a multiple arthritis.

2. The outbreak was traced to the milk supply and has been named "Erythema Arthriticum Epidemicum" in a report by Place.

3. There is insufficient evidence to include definitely the Waverley cases in this group although the similarity of symptoms is suggestive.

CONGENITAL OCCLUSION OF THE INTESTINE

With Report of Four Cases

BY CLARA LOITMAN, M.D.

ATRESIA and stenosis of the intestinal tract, exclusive of the pylorus and anus, are unusual forms of congenital anomalies. The earliest case I have found was reported by Calder¹ in 1733, who described an atresia of the duodenum. The first exhaustive review of this subject was made by Theremin² in 1877. Louise Cordes³, in 1901, made a critical study and analysis of 57 cases of duodenal atresia. Since then there have been comprehensive reviews of the literature, discussions as to the etiology and presentations of cases. The papers of Tandler⁴, Kuliga⁵, and Spriggs⁶ deserve special mention.

From a review of the literature it appears that stenosis is more infrequent than atresia. Occlusion apparently occurs most frequently in the duodenum near the opening of the common duct (Cordes³). Davis and Poynter⁷, in their series of 392 cases, found 134 occlusions of the duodenum, 60 of the jejunum, 101 of the ileum and caecum, and 39 of the colon.

Because of varied quotations it is difficult to accurately determine the frequency of this anomaly. Emil Theremin² found in Petrograd 9 cases of duodenal atresia in 150,000 infants; and in Vienna, 2 cases in 111,451 infants. Ernst⁸ found 2 cases in 41,000 infants in the Copenhagen Royal Lying-in Hospital. Davis and Poynter⁷, in 1922, collected from the literature 392 cases of occlusion from the pylorus to the anus. Dr. Augustus Thorndike, Jr., has found 3 cases of duodenal atresia, and 3 cases of duodenal stenosis in the records of the Children's and Infants' Hospital since 1915. He did not attempt to collect occlusions elsewhere in the

intestinal tract.* From the records of the Massachusetts Homeopathic Hospital since 1912 I have collected 4 cases of congenital occlusion of the intestines, as follows:

Atresia of the jejunum and stenosis of the small and large intestine.

Atresia and multiple stenoses of the jejunum.

Stenosis of the jejunum.

Stenosis of the colon and sigmoid.

Varied hypotheses have been advanced to explain the etiology of this condition. These may be divided into two main divisions:

1. Malformation or Arrest in the Course of Normal Development.

2. Disease of the Fetus.

Under the first division may be mentioned:

(1) Anomalies in the development of the mesenteric artery with consequent malformation of bowel.

(2) Abnormal twisting of the mesentery in the course of normal bowel rotation, with occlusion of blood vessels.

(3) Anomalies in the development of the vitelline duct.

(4) Bland-Sutton⁹, in 1889, offered the theory that atresia and stenosis occur at the site of an "embryological event." He showed that the liver and the pancreas appear as outgrowths from the primitive duodenum and he believed these anomalies were the result of a developmental error at this site.

(5) Tandler⁴, in 1900, demonstrated that the

*Personal communication.

Vaterian segment of the duodenum is occluded by epithelial proliferation during the second month of fetal life. According to Tandler's theory, congenital atresia and stenosis of the duodenum is due to persistent physiological epithelial obstruction.

Under the second division may be mentioned:

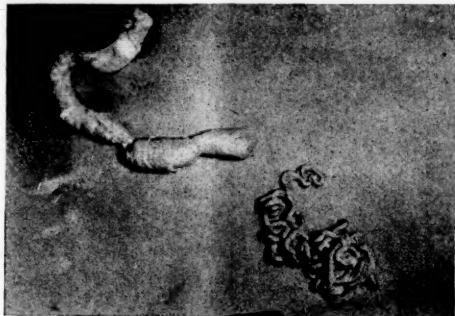
- (1) Embolus in the superior mesenteric artery.
- (2) Fetal peritonitis.—Fiedler, 1864¹⁰.
- (3) Syphilis.
- (4) Intrauterine enteritis.—Thorel, 1899¹¹.
- (5) Volvulus.—Gaertner, 1883¹².
- (6) Intussusception of a loop of intestine with absorption of necrotic bowel.—Chiari, 1888¹³.

These are but few of the many theories which have been ably discussed, particularly by Cordes³

The next day, December 4, jaundice was noted. One teaspoonful of castor oil was given. There was no stool and an enema was again given with no results. The vomiting continued and the vomitus became brownish green in color and slightly foul. The mother was then advised to have the baby admitted to the hospital.

Entrance weight was 4¼ pounds. The physical examination showed a poorly nourished, intensely jaundiced baby. There was no dehydration. The abdomen was slightly distended and a definite peristaltic wave was observed. No tumor was palpable. During the examination the baby vomited with great force. The vomitus came through the nose and mouth.

The stomach was washed and 450 cubic centimeters (measured) of a slightly foul, brownish green liquid obtained. An enema yielded a few small, white, tough curds. The baby was given two ounces of breast milk every three hours. The vomiting of bile and constipation continued. Her condition grew progressively worse and the baby died on the morning of December 9, on her eighth day of life.



CASE 1

and Kuliga⁵, and which have recently been reviewed by Erb¹⁴.

Occlusion of the intestinal tract is interesting not only from the viewpoint of congenital pathology but also from the clinical viewpoint. It is a distinct clinical entity, rarely considered in diagnoses and discouraging as to prognosis. The symptoms may perhaps be best discussed by presenting the main features of cases.

CASE 1. Baby girl Williams, colored, aged 5 days, entered the Pediatric Service of the Massachusetts Homeopathic Hospital on December 6, 1926, at 4:30 P. M. The chief complaints were vomiting since birth, constipation and jaundice.

The baby was born at 1:45 P. M. on December 2, 1926, at full term. The mother's pregnancy and labor had been normal. The baby cried well at birth and except for being small, appeared normal. On December 3, at 2 A. M. the baby vomited green material and bled from the nose. The attending physician gave 20 cubic centimeters of mother's whole blood intramuscularly. At 9 A. M. of the same day the physician noted a coffee ground vomitus. Twenty cubic centimeters of mother's blood was again given intramuscularly. The baby was breast fed every three hours. She continued to vomit a green liquid at frequent intervals, between and after feeding. She passed urine but no meconium. An enema was given and a long, tough, stringy, white curd was expelled.

An X-ray taken on December 8 showed an obstruction of the second part of the duodenum and marked anti-peristalsis. The pylorus and duodenal cap appeared normal.

Autopsy Findings—Permission for an autopsy was granted. The abdomen appeared slightly distended. On opening the abdomen a distended stomach and duodenum came into view. The duodenum showed two annular constrictions and ended in a blind sac. There was no connection between this sac and the rest of the intestine, either by fibrous cord or mesentery. The rest of the intestine appeared worm-like. The proximal end of the lower segment of bowel was found by dissecting the bowel from the sigmoid up. It was found to taper down like the point of a pencil and to be firmly attached by fibrous bands to the anterior surface of the abdominal aorta. The upper segment of the bowel measured 24.50 centimeters in length and 4 centimeters across its widest diameter. The first constriction, which was most marked, was 8 centimeters from the pylorus, and the second constriction 18 centimeters from the pylorus. The lower segment of bowel was 142 centimeters in length and averaged 3.5 millimeters in width. The serosa over both blind ends of the intestine were intact and no scars were seen. The gall-bladder was completely empty. The common bile duct bifurcated at two millimeters before entering the duodenum. The upper segment of bowel contained bile; the lower segment of bowel contained a yellowish white semi-solid. The rest of the body was essentially normal. All the tissues were bile stained.

Microscopic Examination—The gastric mucosa appeared normal. The three layers of stomach musculature were present and showed no abnormalities. A section taken through a portion of the duodenum showed a normal mucosa, but failed to reveal the presence of duodenal (Brünner's) glands. A section taken at the end of the blind sac showed normal jejunal structure. A section taken through the distal segment of the intestinal tract was normal in structure, but the mucosa was slightly atrophied, the musculature was thin and the lumen was very small. The blind end of the distal loop of bowel showed no intussusception.

The absence of duodenal glands and the absence of bile in the lower segment of bowel indicate that the occlusion occurred in the fourth month of fetal life. Annular constriction, partially occluding the lumen of the duodenum, is very unusual (Cautley¹⁵). The obstruction of the duodenum noted in the X-ray, apparently was at the first annular constriction.

CASE 2. Baby White, age 5 days, entered the hospital on May 21, 1918, on the surgical service of Dr. Charles T. Howard. The birth history was negative. The chief complaints were vomiting of bile since birth, complete constipation and distention. The baby had lost 14 ounces since birth. The anus appeared normal and a catheter could be passed up for a distance of 4 to 5 inches. A diagnosis of intestinal obstruction was made. Under chloroform anesthesia an incision was made at the level of the umbilicus. At the middle of the jejunum the intestine was



CASE 2

found to end in a blind pouch. There was a seven-inch space and then the intestine continued as a string-like cord; beyond that was a slight dilation the size of a pea bean and then the string-like cord continued. The large intestine was the size of a crow's quill. The blind pouch of the intestine was brought into the abdominal wound and given vent. The child died on May 23, 1918.

CASE 3. Baby K. S., age 4 days, entered the service of Drs. Harry J. Lee and Milo Green on May 19, 1924. The chief complaints were vomiting of greenish material at frequent intervals since birth, and constipation. Operation was performed on the day of entrance. On opening the abdominal cavity a greatly distended jejunum presented itself. Lower in the abdominal cavity and in the pelvis were small cord-like atrophic loops of bowel. The terminal end of

the jejunum was brought into the abdominal wound and the abdominal wall closed. Prior to doing this an opening was made in the bowel and a metal tube inserted, through which several ounces of a yellowish fluid escaped. Baby died on May 23, 1924.

CASE 4. Baby B., age 2 days, private case of Dr. Thomas E. Chandler, entered the hospital August 11, 1922. The chief complaints were vomiting of bile since birth, and failure to pass meconium. An obstruction was felt in the rectum, two inches above the anus. An incision was made through the left rectus muscle. Neither colon nor sigmoid could be found. Only a cord seemed to spring from the dilated portion of the proximal end of the rectum in place of the sigmoid and colon. An enterostomy was made and a portion of the distal loop of the small intestine brought through the wound. Incision was made in the bowel and its contents allowed to escape. Baby died August 15, 1922. X-ray showed the intestines greatly distended. A barium enema was obstructed at the rectum. X-ray diagnosis was atresia of colon.

The autopsy findings in the last three cases confirmed the operative findings. From the brief descriptions of these cases it is apparent that the symptoms of congenital intestinal occlusion are those of intestinal obstruction. *Vomiting* is almost always present. It was not present, however, in a case of Helmholtz's¹⁶ which lived for two days, or in a case reported by Farr and Fries¹⁷, which lived for eight days. Vomiting is not uncommon in the first days of life, but persistent vomiting occurring before food is taken, or bearing no relation to feedings, is important. The vomitus may or may not contain bile, depending upon whether the occlusion is above or below the ampulla of Vater. Cordes³ has shown that bile may be present in the vomitus even when the occlusion is above the entrance of the common duct, due to an aberrant bile duct opening above the atresia. *Hematemesis* was present in about 65% of the cases collected by Cowell¹⁸ in 1912. He came to the conclusion that in most cases the gastrorrhagia is mechanical in origin resulting from the strain of vomiting in an already overdistended stomach. *Constipation* is usually complete. A small amount of mucus or curds may be passed. The lower segment of bowel may or may not contain bile, depending on the site of the occlusion, and the presence or absence of an aberrant bile duct. Even when the common duct enters the intestine above the occlusion and there is no aberrant duct present, bile may be found in the intestine below the occlusion if the occlusion occurred after the fourth month of fetal life. *Distention* is a common symptom and is mentioned in most of the cases. A low occlusion tends to give a greater amount of distention than a high one. *Visible peristalsis* has not been frequently recorded. It was present in Case 1 and in three cases reported by Farr and Fries¹⁷. *Anuria* and *Icterus* have been occasionally mentioned. Savariaud¹⁹ thinks icterus is due to hypertension in the biliary tract.

While it may not be difficult to diagnose congenital intestinal occlusion, it is difficult to determine the point of obstruction, and it is im-

possible to determine whether the obstruction is single or multiple. Surgery offers the only hope of cure. If there are areas of undeveloped bowel or scattered multiple occlusions, operation is useless. All cases reported to date in which an enterostomy alone was performed as a temporizing measure resulted fatally. I have found four cases in the literature where there has been recovery after operation (anastomosis) on the new-born for congenital intestinal occlusion.

Abel²⁰, in 1899, performed a successful gastroenterostomy on an 8-weeks-old infant with hypertrophic stenosis of the pylorus. This case is frequently referred to in the literature as a case of duodenal occlusion.

Fockens²¹ of Rotterdam, in 1911, reported a successful operation on an 8-days-old infant with atresia of the ileum.

Ernst⁸, in 1916, reported the first case of congenital atresia of the duodenum successfully treated by operation. He performed an enteroentero anastomosis. Five months afterward the child was well.

In the "Management of Sick Children" by Porter and Carter appears the statement that in the practice of one of the authors there is a child, now 4 years old, who was operated on for a congenital atresia of the duodenum.

Dr. George D. Cutler, in 1924, at the Children's Hospital, performed a posterior gastroenterostomy on a 4-days-old infant with an obstruction of the duodenum as shown by X-ray. The child is now 3 years old is apparently normal.*

SUMMARY

Congenital intestinal occlusion is a distinct clinical entity with a discouraging prognosis. The symptoms are those of intestinal obstruction occurring in the new-born. The only hope is surgery and the operation of choice is an enteroanastomosis (Ernst⁸).

NOTE:—Thanks are due to Drs. Charles T. Howard, Harry J. Lee, Milo Green and Thomas E. Chandler for permission to use their cases, and to Dr. Orville R. Chadwell, Professor of Pediatrics, Boston University Medical School.

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DEGREE CONFERRED UPON DR. CLARA EMERETTE GARY

In the account of the Commencement Exercises of the University of Vermont published in the *Burlington Free Press and Times*, there is a copy of the record of the award of the degree of Doctor of Science to Dr. Clara Emerette Gary of Boston. In awarding this degree, the following tribute is expressed:

"*Doctor of Science*.—Clara Emerette Gary, born in Middlesex and bred at Montpelier, trained in medicine at Boston University; first daughter of Vermont to enter the medical profession, senior in service among the still active women practitioners of Boston; pioneer in the teaching of physiotherapy and in the application of X-rays in diagnosis and surgery; bountiful of her service in the World War; a 'woman leader of the deed,' original and resourceful in research, skillful and sympathetic in practice; high-hearted and large-minded in social activities and relations."

SANITARIANS TO STUDY OUTBREAK OF TYPHOID

UNITED STATES HEALTH SERVICE NAMES BOARD TO SEEK SOURCE OF DISEASE IN MONTREAL

The full text of Dr. Cumming's statement follows:

There is grave alarm and apprehension on the part of State and city health officers throughout the United States because typhoid fever is continuing to be present in Montreal. I have requested Dr. J. A. Amyot, Deputy Minister of Health of the Dominion of Canada, for permission from the Dominion and other health authorities in Canada to detail a board of officers of the Public Health Service to visit Montreal and secure the facts as to the source and extent of the outbreak. Permission for this survey has been granted by the Canadian health authorities.

The board will begin its work in Montreal on June 18. While in Montreal this board will secure such other information as might be needed to enable the board to submit recommendations to the Public Health Service for those measures that will be necessary to prevent the spread of typhoid infection from Montreal into the United States.

This board consists of Surgeon L. L. Lumsden, chairman; Surgeon J. P. Leake, Surgeon C. E. Waller, and Sanitary Engineer H. R. Crohurst, all experienced sanitarians of the United States Public Health Service.—*United States Daily*.

**Case Records
of the
Massachusetts General Hospital**

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN
WEEKLY CLINICO-PATHOLOGICAL EXERCISES

EDITED BY R. C. CABOT, M.D.

F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 13271

HEMOPTYSIS, FEVER AND COUGH

MEDICAL AND SURGICAL DEPARTMENTS

An Italian laborer thirty-four years old entered the hospital January 17 complaining of "fever" of a week's duration. He was very ill and disoriented.

For three months or more he had had a dry hacking cough. He had however considered himself well until a week before admission, when he caught cold and had a slight chill without gross trembling accompanied by malaise and followed by fever and cough. He had pain in the right lower chest on respiration and cough. This had persisted. Two days before admission he had bloody sputum. Since that time he had produced very little. His bowels had not moved for four days. He was too ill to give any further history.

Clinical examination showed a somewhat emaciated, sick, "toxic" man, sweating. Skin damp, with a diffuse rash, papular for the most part but pustular in spots. Teeth poor. Marked pyorrhea. Throat red and injected. Tongue coated, dry, cracked. Lung signs and abdominal tenderness and spasm as shown in the diagram. Apex impulse of the heart not seen or

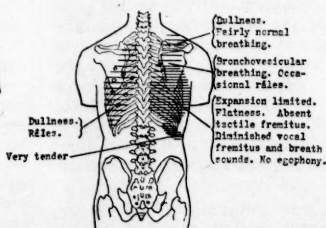
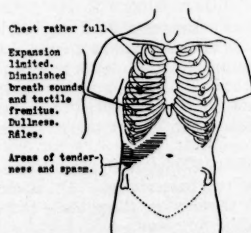
lower half of the right lung was obliterated by an area of increased density which was of uniform character and obliterated the outline of the diaphragm, the ribs, lung markings and cardiac border. The density of the shadow suggested fluid.

The day of admission the right chest was tapped in the eighth interspace at the angle of the scapula. 250 cubic centimeters of thick dark yellow material was obtained which showed 80,000 leucocytes, 75,000 red cells, 90 per cent. polynuclears, 10 per cent. lymphocytes; a very few diplococci and epithelial cells seen. Culture showed streptococci. Blood cultures at this time and a week later showed no growth.

January 18 a trocar thoracotomy was done, the needle entering the pleural cavity in the ninth interspace. A catheter was inserted for a distance of about an inch and a half beyond the trocar. A small amount of pus was allowed to escape. Aspirations were done every two hours. January 20 irrigations with saline were started. The next day they were changed to Dakin's. The temperature fell to 100.6°.

X-ray January 21 showed the dullness in the lower right chest less marked than in the previous plates. The upper border of the dull area was mottled, and there were lines radiating outward from it into the lung field. In the soft tissues outside the bony thorax there were irregular areas of diminished density which suggested gas between the muscle bundles.

January 23 the temperature was 104.2°. The patient coughed up four ounces of blood. The tube was shortened so that its opening inside was flush with the inner portion of the pleural cavity. It drained well. The temperature continued high, the respirations rapid. The irrigations were clear. It was suggested that the irrigations be omitted and 5 c.c. of one per cent. mercurchrome solution used twice a day. The



felt. Pulses normal. Blood pressure 140/100. The rest of the examination was negative.

Urine not remarkable. At entrance leucocyte count 27,600. Sputum negative for tubercle bacilli at four examinations.

Temperature at admission 103°, pulse 120, respirations 21.

A portable X-ray film was not altogether satisfactory on account of considerable motion. The

patient seemed better. January 29 he was irrigating well.

X-ray January 27 showed no appreciable change in the appearance of the chest since the last plate. The dullness occupied the greater part of the right side of the chest. The upper border of the dull area was irregular. There was considerable mottling in the lung above it. The heart was displaced toward the left.

January 30 the patient coughed up about six ounces of bright red blood. Morphia was given by the clock. The temperature continued high. Attempts were made to control the cough with codeia. Another culture from the cavity showed streptococci and Gram-negative and Gram-positive bacilli. Cultures a week and two weeks later showed pneumococci and the same bacilli. A smear from the cavity showed very rare polymorphonuclears, 0-1 diplococci per oil field. Another February 14 showed no organisms, 0-12 leucocytes per field.

February 8 a portable X-ray plate showed that the shadow in the right chest had diminished in density, particularly in the lower portion. The outline of the diaphragm was now visible on this side. There was a band of mottled dullness extending outward from the hilus across the chest, and also a triangular area of greater density with sharply defined borders which extended inward from the axillary wall in the region of the interlobar septum.

February 10 the temperature was subsiding. The patient felt well. The irrigations went well. February 13 the X-ray shadow of the right base was somewhat more dense, but this was thought probably due to underexposure of the plate. February 25 a culture of pus from the cavity showed a profuse growth of very motile Gram-negative bacilli, probably *B. proteus*. A smear was negative. February 26 the patient was up in a chair. The temperature was flat. March 1 he was walking. The cavity was growing smaller.

March 2 X-ray showed the area of consolidation in the right lower chest still present. A line of diminished density could be seen between it and the diaphragm. There was absence of respiratory motion on this side.

March 3 the temperature rose to 101°, the pulse to 136, and the patient coughed up three ounces of bright red blood. Next day the temperature was normal. The aspirations were still slightly bloody. There was no more hemorrhage. He did fairly well. The cavity continued to diminish in size. A smear March 11 showed 0-20 bacilli per oil field; another March 17 showed 10 streptococci and staphylococci per field.

March 13 the area of dullness previously seen by X-ray appeared somewhat more extensive. The upper border was now very indefinite in outline.

Early in the morning of March 17 the patient went into sudden collapse, seemingly cardiac. Examination revealed a very large, hard, nodular liver the edge of which was below the umbilicus, and free fluid in the abdominal cavity. The heart sounds were weak and distant. Within an hour and a half the patient died.

DISCUSSION

BY RICHARD C. CABOT, M.D.

NOTES ON THE PHYSICAL EXAMINATION

There is no evidence that the heart is displaced.

The abdominal tenderness and spasm is of the sort that sometimes has led to surgical operations.

The signs in the diagram are those of fluid. Unless something unusual turns up that is what we expect to find.

I should be much obliged if we could have the X-ray plates demonstrated to us.

DR. RICHARD DRESSER: We have this area of absolute dullness at the base which obscures the outline of the heart and diaphragm. The heart appears to be displaced perhaps a little to the left. That of course is the picture of fluid. That is what we should have to diagnose it. The later plates show very much the same picture.

DR. CABOT: Is there air with the fluid? I thought one plate showed a horizontal border, and did not know whether we should get it without air above it.

DR. DRESSER: I think we might. It is rather surprising to get this clear area at the costophrenic angle. We should expect the fluid to come down and fill up this angle. There is one thing we ought to keep in the back of our heads when we see a massive dullness of this sort, and we do usually think of it but do not always mention it. That is primary tumor of the lung. I recall a case where a woman was tapped a great number of times because the X-ray man insisted that she had fluid and it turned out to be a tumor of the lung. The two cannot usually be differentiated from the X-ray alone.

DR. CABOT: So that the evidence from these plates, so far as radioscopes goes, is of fluid and essentially nothing else.

Four ounces is a good deal of blood to cough up. With empyema a person has no right to cough up blood in quantity like that. I take it everybody's diagnosis in the beginning was empyema, but I never heard of an empyema behaving like that unless there was something else too.

I do not think we get anything in particular out of this bacteriology. Dr. Richardson, do you think there is anything there to help us in diagnosis?

DR. OSCAR RICHARDSON: Nothing except that there is a great deal of trouble in the lung.

DR. CABOT: Yes, but that we knew before. I do not see that it helps us.

Without knowing anything about it, the X-ray report of February 8 sounds as if it might be an interlobar collection of pus. Pus often does pocket there. If it is not that I do not know what it is.

The only thing shown by the chart which

would give any anxiety is the high pulse. It continues in the vicinity of 110 or 120 while the temperature is normal or subnormal. Otherwise one would think he was going to get well March 1. He is walking about, and the cavity, certainly taken to be an empyema cavity, is getting smaller.

I am not quite sure what diminished density means between the area of consolidation and the diaphragm.

DR. DRESSER: That was the line you referred to. I suppose it might have been air introduced. It looks more like lung to me.

DIFFERENTIAL DIAGNOSIS

This death is very dramatic. A large, hard, nodular liver with the edge below the umbilicus ought to mean metastatic cancer of the liver, if taken at its face value. Apparently they had not had much curiosity before about his abdomen. Probably they had their attention, as we so often do, on the chest where so much was going on. I think we ought not to get too excited about that liver. The conditions were found on the day that he died, and they evidently were quite flabbergasted. But it seems very strange that a secondary carcinoma of the liver, which is what we have to take that to be if the examination is correct, should not have shown more suggestion of a primary source. Now of course, as previously suggested, that primary source might be in the lung. I do not know whether the X-ray appearances are consistent with cancer of the lung?

DR. DRESSER: Yes, they are.

DR. CABOT: It does not look like a metastatic lung process, does it?

DR. DRESSER: If it is cancer it would be primary.

DR. CABOT: Why should it not be cancer? A cancer by blocking the bronchus can lead to blocking of the exit of secretions and through that to abscesses and empyema. We cannot doubt that he had empyema. He is young for cancer, but not extraordinarily young for it.

The other thing he might have would be abscess of the lung, either bronchiectatic or single, and I do not know any way to rule that out. A patient with abscess of the lung can bleed as he has bled. An abscess of the lung can produce a secondary empyema such as was drained here. On the other hand, I do not know that there is anything in these X-ray appearances to suggest abscess, and it ought to show on such plates.

DR. DRESSER: Not necessarily. In order to diagnose abscess one must see a cavity and a fluid level, and we don't always get that in abscess.

DR. CABOT: Then the X-ray does not negative the possibility of abscess, and I do not know how it can be negated. Of course when there is or has been pus in the right pleural cavity it

is very common to find a normal liver down at the umbilicus, and the fact that this liver is big does not surprise me, even though there is no pathology below the diaphragm. But if it is nodular that is different. I should like the examination repeated on several days so as to be sure of it. Unfortunately there was not time.

If it was nodular it might have been cirrhosis, although it is rare for anybody to feel anything that he supposes to be nodules through the abdominal wall in cirrhosis.

DR. RICHARDSON: Does the X-ray indicate at all where the anterior margin of the liver is?

DR. DRESSER: It might if taken particularly for that, but we did not examine for the patient's liver.

DR. CABOT: It is also stated that he had free fluid in the abdominal cavity. That again is important if true. That would go rather better with cirrhosis of the liver than it would with cancer, although it could go with either.

How are we to explain his sudden fatal collapse? There is nothing to suggest disease of the heart. His heart has been a little displaced, as X-ray reveals, but not in such a way as to warrant the supposition that it is interfered with in its motion by the displacement. Otherwise there has not been a thing recorded to make us favor cardiac disease. I do not favor the idea, therefore, that it was a cardiac death. If not a cardiac death, what could it have been? It might have been from hemorrhage. It is true we have no description of the clinical state ordinarily associated with hemorrhage. It is conceivable that it might have been due to a general peritonitis, accounting thereby for the free fluid as well as the collapse. But I do not expect general peritonitis to kill a man within an hour and a half of the time it comes, and if we put that in at all we should put it in as a sudden perforative peritonitis at the very end.

I do not think I can go any further.

Let us begin with the things we are surest of. He certainly had an empyema cavity. But I think there is no question that he had something else, and on the whole I think that something else is more probably cancer in the lung than anything else I can think of. If he had cancer of the lung he may perfectly well, I suppose, have had it in the liver too, but I do not feel certain of that in view of the lateness of the time when the examination was made, so near death. So what is going to be found below the diaphragm I do not know, and I don't think we have facts enough to make any guesses about it. I think empyema plus a cavity which might be abscess or bronchiectasis, most probably due to primary cancer of the lung, is the best I can do. I do not believe there will be any evidence of cardiac disease. We are not told anything about his urine.

MISS PAINTER: The specific gravity is 1.015 to 1.026. The urine was cloudy at one of six

examinations and turbid at two. There never was any albumin or sugar.

DR. CABOT: We have no reason to consider kidney disease, then, that I see. Dr. McIVER, has anything occurred to you, in what you have been able to follow of the case?

DR. MONROE A. McIVER: It is obvious that he did enter with empyema. This diagnosis was confirmed by the physical examination, by X-ray, and by puncture. The tap showed pus and organisms. There was so much pus in his chest at that time that it would confuse any attempt to go farther with the diagnosis. The signs of pathology in the lung would be masked by the empyema. It might have been either a pyogenic lung abscess that had ruptured into the pleura giving an empyema, or it might possibly have been a tuberculous infection that became secondarily infected. It seems to me that the indications were very clear at the time of admission to drain this empyema, whatever was back of it.

DR. CABOT: Would you like to hazard a guess as to what was back of it?

DR. McIVER: Unfortunately I know the diagnosis.

DR. CABOT: I said I was confident a man could not cough up four and again six ounces of blood by reason of empyema alone. I have seen a cancerous lesion bleed like this, an abscess cavity bleed like this, and a bronchiectatic cavity bleed like this.

A PHYSICIAN: Do you get this from syphilis of the lung?

DR. CABOT: I do not know anything about syphilis of the lung.

A PHYSICIAN: He had a rash.

DR. CABOT: Yes, but it faded out and we do not hear anything more about it. On general principles I will make a bet against syphilis of the lung.

A PHYSICIAN: How about tuberculosis with tuberculous peritonitis?

DR. CABOT: He had a negative sputum. The apices of the lungs were clear. They did not find out anything about his abdomen until the very end. But I think he would probably have complained of his abdomen if tuberculosis had been there. Most adults do. I think we can rule out tuberculosis.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Lobar pneumonia.

Empyema and question of malignancy with metastases.

Trocar thoracotomy.

DR. RICHARD C. CABOT'S DIAGNOSIS

Cancer of the lung.

Cancer of the liver?

Empyema cavity.

Pulmonary abscess or bronchiectasis.

ANATOMIC DIAGNOSES

1. Primary fatal lesions

Malignant tumor (neuroblastoma?) involving the bronchial lymph glands, right lung, liver, kidneys, and retroperitoneal lymph glands.

2. Secondary or terminal lesions

Compression of the right primary bronchus. Bronchiectasis with chronic pneumonitis and abscesses of right lung.

Edema of the lungs.

Slight ascites.

Congestion of the liver, spleen and kidneys.

Wet brain.

3. Historical landmarks

Chronic pleuritis.

Operation wound.

DR. RICHARDSON: He was a well developed white man, but very poorly nourished. We opened the head and found a wet pia with negative vessels of Willis, sinuses, and middle ears, pineal and pituitary glands. The brain weighed 1300 grams. The tissue was wet, but showed nothing else. The bone marrow of the thoracic vertebrae was negative.

On the right side of the back was the trocar wound mentioned. On examining the body at that time what was apparently a greatly enlarged liver was easily felt, and on opening the peritoneal cavity we found it was an enlarged liver, reaching to the pubes.

The peritoneal cavity contained about 400 cubic centimeters of thin reddish clear fluid. The appendix was negative. The gastro-intestinal tract was negative. The mesenteric glands were negative, but the retroperitoneal glands along the curvature of the stomach and in the lesser omentum were markedly enlarged, some of them five centimeters across. Their tissue was pale, pulpy, and yielded thick, opaque whitish fluid material, a rather unusual picture for the ordinary cancer, more like soft malignant lymphoma.

The liver reached nearly to the pubes and extended from side to side. It weighed 4600 grams. The diaphragm was at the fifth rib on the right, at the fifth interspace on the left.

The right pleural cavity was obliterated by old adhesions. On the left there were a few scattered adhesions. The trachea and left bronchus were negative, but the right primary bronchus was pressed upon and considerably narrowed by a mass in the situation of the bronchial glands. These enlarged glands practically encircled the bronchus, and the bronchus contained considerable pus. The bronchial glands on the right side were markedly enlarged, some of them seven centimeters across. They were comparatively small on the left. The glands showed a malig-

nant tissue similar to that in the retroperitoneal glands. The apex of the right lung was negative. The upper lobe showed spongy brownish red tissue with moderate edema. There were no areas of consolidation. The lower and middle lobes showed pneumonitis and here and there small abscesses, with the bronchi dilated and containing pus,—bronchiectasis and small abscesses. In the upper part of the middle lobe there were smaller and larger irregular areas showing granular surfaces, which raised the question of malignant tissue. They were masses of malignant tissue. The apex of the left lung showed a spongy brownish-red tissue, with moderate edema,—practically negative. The trouble was all on the right.

The heart weighed 229 grams. That is a very small heart for a man. The myocardium, valves and cavities however showed nothing for record. The coronaries were free and negative. The circulatory apparatus generally was negative.

On the surface of the liver were scattered masses of neoplasm, and in the substance numerous smaller and larger masses of neoplastic tissue. The gall-bladder, bile ducts, pancreas, spleen, adrenals, and kidneys were negative, except that in each kidney, extending from the surface inwardly, there were several small masses of neoplasm, the largest two centimeters across. Otherwise the kidneys were negative. The pelvis, ureters, bladder, prostate, seminal vesicles and testes were negative.

From the description it is apparent that we were dealing with a tumor which had involved the liver, lungs, and glands mainly, with the remaining organs out of the picture. It was an unusual tumor, not a lymphoma, and the other organs being ruled out it is not adenocarcinoma from any of the usual sources, and the character and arrangement of the cells in the tissue make the anatomical diagnosis probable neuroblastoma. Once in a while neuroblastomas are found in this situation.

DR. CABOT: Where would you suppose it was first?

DR. RICHARDSON: Possibly in the region of the bronchial glands.

A HOUSE OFFICER: How about the bronchus shutting down?

DR. CABOT: He did not have respiratory indicate why he died so suddenly. symptoms. I do not think there is anything to

dition that no reliable or adequate history could be obtained. Only after many attempts could he finish his sentences. For the most part he lay in a semistupor, moaning constantly and breathing stertorously.

He felt fairly well and even worked more or less until the first of January. He gave a vague history of lifting a rock and straining his back at this time. However that may be, he said the first thing that troubled him was pain over the sacrum. Since that time he had had dull epigastric pain, worse after eating. He vomited the day before admission and the morning of admission. Before that he had been nauseated at times but had not vomited. He had lost a great deal of strength and probably some weight. He denied having had any urinary difficulty of any kind. He urinated last about three hours before admission. A physician attempted at that time to catheterize him without success. The physician said that the patient had been bleeding from his gums following the extraction of teeth.

Clinical examination showed a pale, emaciated man with a slightly icteric tinge to the skin. Sockets of several recently extracted teeth plugged with cotton. Marked pyorrhea. Apex impulse of the heart felt in the fifth space. No enlargement to percussion. Action regular, rapid. Sounds of good quality. A loud systolic murmur heard all over the precordium, best at the apex. No diastolic. Artery walls thickened and tortuous. Blood pressure 112/60. Lungs clear. A marked degree of spasm of the rectus muscles, probably voluntary. The patient complained vehemently when pressure was made on any part of the abdomen. There was dried blood about the penis, scrotum, and the adjacent skin of the thighs, and a dried clot in the urinary meatus. The prostate was large, very hard, and irregular. There was induration extending out toward each seminal vesicle. The median prostatic groove was obliterated. There was no suprapubic dullness. The bladder could not be felt. Over the left hip, left shin and foot were ecchymoses. The pupils were contracted and did not react at all to any stimuli. The other reflexes are not recorded.

Urine not recorded. Hemoglobin 35 per cent. Blood smear showed a marked secondary anemia with apparent reduction in the number of platelets (not counted); the leucocytes appeared normal. Non-protein nitrogen 143 milligrams.

Temperature 97.9° to 99.9°, pulse 90 to 103, respirations not remarkable.

The bladder could not be felt. When a catheter was passed it was found to contain only two ounces of urine. The patient was given morphia. Fluids were given suspectorally because of his nausea. On the day following admission he seemed to be somewhat more comfortable. That evening he died.

CASE 13272

DEATH FROM CANCER AS SUCH

UROLOGICAL DEPARTMENT

An English laborer fifty-nine years old entered March 27 complaining of pain in the back and the abdomen. He was in such extreme con-

DISCUSSION

BY EDWARD L. YOUNG, JR., M.D.

I think the only thing we can do in this case is to pick out the facts of which we are sure, because the history as a whole seems to me of little value. Dull epigastric pain, worse after eating, is a very vague symptom. The vomiting came only the day before admission when he was *in extremis*, and might mean nothing, and there was questionable loss of weight. The fact that there were no urinary symptoms is perhaps important.

Assuming that prostatic examination to agree with what I should have felt, he has carcinoma of the prostate, and from the description it is extending up in such a way that it might conceivably occlude the ureters and in that way cause back pressure damage in the kidneys. The fact that he had had no difficulty in urination, the fact that a catheter was passed in this hospital, seem to me to rule out any serious obstruction that would itself have damaged his kidneys. The fact that someone else had difficulty in trying to catheterize him is a thing we see so frequently when there should not have been any serious difficulty that I do not think it means anything.

The hemoglobin is low. The non-protein nitrogen is considerably increased.

Then they speak of the abdominal pain and the fact that he objected to palpation. Spasm of the rectus muscle, even though they say it was probably voluntary, may mean that he has a peritonitis. Of course we have no cause for that peritonitis given in the story or in anything else in the examination unless we assume that he has a spread of carcinoma somewhere in the intestinal tract with subacute perforation.

It seems to me that the most conclusive evidence in the examination is the thing that points best to the cause of death, and that is renal insufficiency, possibly due to the obstruction of ureters from carcinoma of the prostate, which I believe is there. I do not think we have a right to say anything more.

DR. CABOT: Do you think that blood about the urinary meatus was due to attempts to catheterize?

DR. YOUNG: Yes, and I do not believe that amounts to much, because we see so many cases where this happens and yet we find no obstruction to a catheter.

DR. CABOT: Have we any X-rays in this case?

MISS PAINTER: No.

DR. YOUNG: He died about thirty-six hours after entry.

DR. CABOT: It would be a good chance to see if any bone metastases had occurred.

DR. YOUNG: Metastases from prostate are very apt to go to the bones. I have seen a number of cases go to the spine. So that the pain he speaks of may be metastatic. I have seen a

few cases go, without other evidence of metastasis, to the brain, and one or two to the lungs. In my own experience at least that has been the commonest place of metastasis. I would like to ask what, from the pathological point of view, is the commonest point.

DR. CABOT: I was very much struck in a case at the Peter Bent Brigham Hospital where there had been nothing to point in the least to the prostate. There were a number of X-ray plates, and a visiting X-ray expert said, "From those X-rays of the bones I believe that is carcinoma of the prostate." He said that the particular way it was distributed in the bones was characteristic of that particular metastasis, from the prostate. I was very much impressed because he actually predicted the prostatic lesion from an X-ray of the chest.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Carcinoma of the prostate gland.

DR. EDWARD L. YOUNG'S DIAGNOSIS

Carcinoma of the prostate.

Renal insufficiency, possibly due to obstruction of ureters from carcinoma of the prostate.

ANATOMICAL DIAGNOSIS

1. *Primary fatal lesion*

Adenocarcinoma of the prostate with invasion of the bladder and metastases to retroperitoneal glands.

2. *Secondary or terminal lesions*

Pulmonary congestion.

Hypertrophy of the bladder.

DR. MALLORY: There was a cancer of the prostate here which had extended through into the bladder about the trigone and the orifice of one ureter. There was not, however, any evidence of damage to the kidneys. Both were normal in gross and histologically.

No metastases were noted in the bones, but of course we do not have a chance to examine many bones in our ordinary incision, but no metastases were found in the skull, which was examined in this case, or in the brain. He did have a large number of glands in the retroperitoneal tissues which showed definite metastases. Otherwise the organs were essentially negative.

DR. YOUNG: But why did he die?

DR. MALLORY: He had a moderate degree of edema of the lungs. That was all we could find.

DR. CABOT: Don't you think that high non-protein nitrogen is quite interesting with normal kidneys and one ureter partially blocked?

DR. YOUNG: Someone brings up the question as to whether a reflex anuria could have occurred and whether it might have killed him. This one ureter was blocked gradually, and re-

flex anuria never comes on under those conditions. It comes on with some sudden blocking of one side, as for instance a stone in a kidney pelvis which suddenly moves and occludes the outlet, whereupon the other kidney, itself generally damaged, may shut down entirely. In this particular case we have no anatomical proof of the cause of death, and it seems to me we must lay it to the toxemia of the cancer.

DR. R. V. BROKAW APPOINTED FIELD REPRESENTATIVE

THE appointment of Dr. Raymond Voorhees Brokaw as Field Representative of the American Society for the Control of Cancer has been announced. Dr. Brokaw resigned his position as Superintendent of Health of Springfield, Illinois, and took up his new work on June sixth.

Dr. Brokaw is a native of New York City, attended Wesleyan University, and graduated from the College of Physicians and Surgeons, Columbia University. He brings to the Society broad experience in public health work both in this country and abroad.

As Field Representative his duties will take him throughout the United States where he will meet state chairmen and other persons engaged in carrying on the campaign for the control of cancer. He will act as liaison officer to carry information and to collect it.

Dr. Brokaw takes the position left vacant by the resignation of Dr. William F. Wild, who, during his twenty-nine months with the Society, visited every state in the Union, consulting state chairmen and other medical men, as well as dentists, nurses and leaders in public health work in the United States.—*Campaign Notes of the American Society for the Control of Cancer.*

THE GOVERNOR AND ATTORNEY GENERAL SECURE WHISKY*

WELL, well! So the governor as well as the attorney-general of Indiana are lawbreakers. Both procured whisky to be used as a medicine for members of their families who were desperately ill. Such conduct is prohibited by law and is punishable by fine or imprisonment. Indiana's "bone dry law" absolutely prohibits a physician from either prescribing or giving any alcoholic beverages, no matter how small the quantity nor how urgent the need for such a remedy to save life. The question is, what will Rev. Shoemaker and all other prohibition fanatics do about this flagrant violation of Indiana's laws? The attorney-general has written an open letter to the governor calling upon that official to petition the next Indiana Legislature to amend the state pro-

*Extract from an Editorial in the June 15 Indiana State Medical Association Journal.

hibition law to conform to the federal law governing the matter, so that alcoholic beverages may be obtained by physicians and prescribed by them for illness under appropriate restrictions.

JUVENILE DELINQUENCY IN GREAT BRITAIN

IN March, 1927, the British Departmental Committee on the Treatment of Young Offenders reported a decrease of 26 per cent. since 1913 in the number of charges proved against boys and girls in the juvenile courts, and of 69 per cent. in the number of children and young persons sent to institutions by court order. In the past five years 40 certificated schools receiving such children were closed. The committee recommended raising the age for juvenile-court jurisdiction from 16 to 17 years, the practical abolition of imprisonment for young persons between those ages, restrictions on the imprisonment of all offenders under 21 years, and the abolition of capital punishment for persons under 18 years. It also recommended the establishment of "re-mand homes" for the examination and observation of offenders under 21 years, whether dealt with by juvenile or adult courts.

CUBA RESTRICTS CHILDREN'S ATTENDANCE AT MOTION PICTURE THEATRES

A recent decree by the President of Cuba forbids the admission of children under 14 years of age to motion-picture theatres after 8:30 p.m., except on Sundays and holidays. Fines are imposed for violations of this decree, and the money collected will be used to purchase educational films for the public schools.—*Bulletin United States Department of Labor.*

SCHOOL DENTAL-HYGIENE WORK PAYS

BRIDGEPORT, CONN., has carried on school dental-hygiene work for 10 years. Recently a dental survey was made of 24,000 children from the kindergarten to the eighth grade in its public and parochial schools. Comparing the results with those of the examination of 1,000 children in another community of the same State where no school dental-hygiene work has been done, it was found that 8 per cent of the Bridgeport children and only 2 per cent of the children of the other community had no fillings and no cavities.

Findings for the 16 racial groups among the Bridgeport children showed very little difference that could be attributed to nativity, but children from sections of the city where the standard of living is high had the better teeth.—*Bulletin United States Department of Labor.*

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HEARING BEFORE THE MASSACHUSETTS COUNCIL ON THE OBJECTIONS TO THE NOMINATION OF DR. HORACE D. ARNOLD

As previously announced in the daily press, His Excellency, Governor Fuller, nominated Dr. Horace D. Arnold for consideration by the Council for appointment as a member of the Board of Registration in Medicine. The Council conducted a hearing June 29th, 1927, for the purpose of giving opponents and proponents an opportunity to present arguments with respect to this appointment. Dr. E. L. D. Turner, who has appeared before committees of the legislature on several occasions in opposition to raising the State standards of medical education, was the only objector. Dr. Turner is associated with the College of Physicians and Surgeons of Boston and seems to enjoy delivering his diatribes aimed at the American Medical Association. He assumes that the tyrannical and baneful influences of this organization are so powerful that the states are merely puppets in the hands of the medical trust as exemplified in the A. M. A. and his argument was built on the idea that Dr. Arnold's influence has been, and probably will be, particularly malign because of his

membership on committees of the A. M. A. and the Council on Medical Education. He would have the Massachusetts State Council believe that Dr. Arnold is the wicked giant who would revel in the slaughter of the innocents who are not in the folds of the millionaire medical schools. If he really believes all that he says, his mind must be closed to the advantages of a liberal medical education and the value of a good preliminary training.

Drs. Thomas J. O'Brien, Timothy Leary, Alexander S. Begg, P. H. Sylvester, and W. P. Bowers endorsed the action of the Governor and tried to show the councillors that the laws governing medical registrations are the product of State Legislatures and that the function of the A. M. A. so far as influencing law makers is only that of a body engaged in compilation of facts and presenting arguments based on evidence. Further that the A. M. A. has not taken upon itself the functions of trying to influence legislations in the different states only so far as legislators may profit by material which is helpful to those who are desirous of knowing what is being done in educational matters.

The papers later announced that the nomination of Dr. Arnold was confirmed by the Council.

HEROISM OF THOSE ENGAGED IN DEALING WITH COMMUNICABLE DISEASES

It is almost commonplace to refer to the disregard of danger by doctors and nurses. The weekly *Bulletin of the City of New York Department of Health* for June 4 in its leading article reports eight cases of communicable diseases among its employees for April, 1927, and of this number three were nurses who developed diphtheria.

Fortunately heroism is not a rare human virtue. We see it every where among the conscientious public servants who, for example, may be policemen, or firemen, or engaged in many other kinds of work.

In the particular instance of these diphtheria cases the question comes to mind as to the responsibility of the health department. In a casual way the suggestion is made in the report that "every pupil nurse should be given diphtheria toxin-antitoxin inoculations." Also the question since the department of health recognizes the importance of this preventive measure why is its use not obligatory?

If a nation sent a soldier into battle without the best equipment designed to repel attack and avoid undue casualties, it would be the nation's fault if he was killed or injured.

We do not happen to know how many health departments require diphtheria toxin-antitoxin immunization or vaccination against smallpox of its nurses who come in contact with these diseases, but if this custom is not in vogue health departments are losing an opportunity for main-

taining a publicity campaign and are to a considerable extent responsible for every case of either of these diseases which may exist in its corps of nurses.

The suggestion of the desirability of immunizing nurses is one of the best illustrations of the old saying referring to locking the stable door after the horse thief has made his rounds.

If health departments are not protecting their workers, somebody ought to make it plain that they are open to pointed criticism.

FATALITIES DUE TO AUTOMOBILES

A STUDY of this subject so far as it relates to the mortality rate in seventy-seven of the large cities of this country shows that in 1926, January had a rate of about 22.5 per 100,000 of the population which rapidly declined to the latter part of April with the figure of about 14.2, followed by a rapid climb to 22.2 in June, a slight falling off to 19.4 in July and then a steady rise to 27.3 in early November followed by a drop to 21 in January, 1927. Thus far the low of 1926 in March was not reached but nearly the same rise in April and May of this year is recorded with a slight falling off in June. The explanation is apparently true that in the winter months fewer automobiles are on the road and those driven are to a greater degree handled by those who are not on pleasure bent. With July comes the vacation period with many more inexperienced drivers operating cars and the toll of lives mounts higher with the hazards of autumn road conditions.

It is apparently true that novices have a period of low efficiency during the early experiences with motor cars, and of course each year brings a considerable number of inexperienced drivers who are learning the art and science of operating during the period of greatest road congestion.

It would be interesting to know how large a proportion of novices are concerned in automobile accidents and whether the half dozen instructions given to aspirants for licenses really fit the average person to handle automobiles, and also whether senescence is a contributing factor in accidents.

THIS WEEK'S ISSUE

CONTAINS articles by the following authors:

CLIFTON, HARRY C., B.S.; M.D. University of Pennsylvania Medical School 1901; F.A.C.S.; Attending Surgeon St. Francis Hospital, Hartford, Connecticut; Consulting to the Manchester Memorial and the Bristol Hospitals. Address: 30 Farmington Avenue, Hartford, Connecticut. Associated with him is

LANDRY, BENEDICT B., M.D. Harvard University Medical School 1920; Junior American College of Surgeons; Attending Surgeon Municipal Hospital, Hartford, Connecticut. Address: 30 Farmington Avenue, Hartford, Connecticut.

They write on "Fibromata of the Intestines, Report of a Case and Review of the Literature." Page 8.

JONES, LYMAN A., A.B., M.D. Harvard University Medical School 1891; Massachusetts State District Health Officer 1907-1927, now Superintendent Pondville, Mass. Associated with him is

LOMBARD, HERBERT L., A.B.; M.P.H.; M.D. Bowdoin Medical School 1915; Epidemiologist, Massachusetts Department of Public Health. Their subject is "Investigation of Cases of Unidentified Illness in Haverhill, Massachusetts." Page 19.

LOITMAN, CLARA, M.D. Tufts Medical School 1923; Instructor in Pediatrics in Boston University Medical School; Second Assistant Visiting Physician to the Pediatric Department of the Massachusetts Homeopathic Hospital and Assistant Visiting Physician to the Pediatric Department of the New England Hospital for Women and Children; Supervisor of Nutrition Classes, Boston Public Schools. Her subject is "Congenital Occlusion of the Intestines with Report of Four Cases." Page 21. Address: 20 Charlesgate West, Boston.

MISCELLANY

MONTREAL TYPHOID OUTBREAK

THE world has been amazed at the typhoid epidemic that has scourged Montreal, Quebec, for the past few months with approximately 4,000 reported cases and nearly 300 deaths. The figures given underestimate rather than overestimate the wide-spread extent of this epidemic.

The outbreak is attributed to the infection of the milk supply by a carrier, but back of this simple statement are rumors of political interference and the subordination of public health control activities to meet political exigencies.

That the trouble lies largely or wholly within the local Montreal territory is seen by the fact that the milk supply in the provinces of Quebec and Ontario is permitted entrance to the United States. The department of health of Montreal is reported to be working as efficiently as possible against heavy political odds. The dairy industry is clamoring for adequate scientific control of the pasteurization and distribution of milk supplies.

On the other hand the mayor of the city is reported to have said that 3,000 cases of typhoid fever in a city the size of Montreal was nothing out of the ordinary and was to be expected.

Such reports are very disquieting to health workers. While we believe there are few city officials who would risk the storm of protest and indignation that would descend upon their heads were they to make such statements as those attributed to Montreal's mayor, there is doubtless a tendency in certain quarters to minimize disease outbreaks largely through fear of the effect

upon business conditions. Realizing this the recent Conference of State and Provincial Health authorities of North America unanimously passed a resolution to warn all those contemplating a visit to Montreal to defer such visit until another year unless they were protected by typhoid vaccination. Likewise it was felt that conventions and other meetings that would draw visitors from large areas should be held elsewhere until all possible danger was past. This financial loss might have more of an appeal than one made on health or other humanitarian grounds.

There is also the danger to be faced of the wide distribution of carriers due to recovered and unrecognized cases. There is almost sure to be outcroppings of typhoid in unusual localities, as vacation resorts and summer camps, where recovered cases may be visiting or working.

The true story of this outbreak, if ever written, will serve many useful purposes, not the least of which will be to point out the results that follow the prostitution of public health work to satisfy political greed.—From *"The Nation's Health."*

EIGHT STUDENTS IN THE COLLEGE OF PHYSICIANS AND SURGEONS ARE GIVEN M.D. DEGREE

THE forty-eighth annual commencement of the College of Physicians and Surgeons of Boston was held June 29th, 1927, in the auditorium of the Municipal Building at Shawmut Avenue and West Brookline Street, Boston. Eight graduates were given degrees of M.D.

The President of the College, Everett Priest; Angus S. MacKenzie, Clerk; Carolus M. Cobb, Dean, and Edward L. Dwight Turner, conferred the degrees.

The names of the graduates were not recorded in the statement published in the daily papers.

A STATISTICAL ANALYSIS OF THE EXPERIENCES OF THE MASSACHUSETTS DEPARTMENT OF MENTAL DISEASES

DR. GEORGE M. KLINE, Commissioner of Mental Diseases of Massachusetts, has placed Dr. Neil A. Dayton in charge of a statistical analysis of the past experiences of the Massachusetts Department of Mental Diseases in order to furnish information which will aid in working out the problems now confronting the State with respect to the new building program, the large feature of which is the Metropolitan Hospital authorized by the legislature.

Research will also be included because it is recognized that research work in psychiatry is regarded as a definite function of the State.

Dr. Dayton is Director of the Division of Mental Deficiency and was formerly Assistant Superintendent at the Wrentham School.

The work of the Massachusetts Department of Mental Diseases is watched with interest by psychiatrists in other states.

BOSTON DEDICATES THIRD HEALTH UNIT

LOCATED AT DORCHESTER AND WEST FOURTH STREETS

MEDICAL men and laymen joined in congratulating the city of Boston on its work in preventive medicine, which was exemplified by the dedication of Boston's third health unit established under the George Robert White fund. The new unit is at Dorchester and West Fourth streets, South Boston.

The dedication address was delivered by Dr. Haven Emerson, professor of public health at Columbia University, who has advised the administration frequently on matters of public health in the last two years. Dr. Emerson declared that Boston is taking the lead in public health work, particularly in the health unit system made possible by the White fund.

The dedication ceremonies at South Boston were followed by a luncheon at the Ritz-Carlton, at which the speakers were Eliot Wadsworth, Judge Edward L. Logan, Congressman James A. Gallivan and the Rev. M. E. Toomey. Mayor Nichols presided.

George E. Phelan, manager of the White fund, presided at the dedicatory exercises. The Rev. John A. McClelland delivered the invocation, and Charles A. Coolidge, one of the architects of the building, delivered the keys to George R. Nutter, president of the Boston Bar Association and a trustee of the White fund. Mr. Nutter then presented the unit to the city, and Mayor Nichols accepted.

Other speakers were Dr. Francis X. Mahoney, city health commissioner; Dr. Edward F. Timmins, president of the South Boston Medical Society; Dr. J. W. Bartol, president of the Boston Health League and Dr. George H. Bigelow, state health commissioner. The Rev. Joseph F. Copping delivered the benediction.—*Boston Herald.*

HEALTH REPORTS SHOW GAINS IN SMALLPOX AND TYPHOID FEVER

STATISTICS BASED ON ADVICES FROM 98 CITIES IN ALL PARTS OF COUNTRY

TYPHOID fever and smallpox continued to be higher in prevalence this year than in 1926, reports from State health officers for the week ended June 4, 1927, show as compared with the corresponding week of 1926, disclosing respective increases of more than 100 cases of each disease, the United States Public Health Service announced June 24 in its weekly statement on the prevalence of communicable diseases.

CASES OF TYPHOID FEVER

Forty States reported 408 cases of typhoid fever for the current surveyed week, as compared with 288 for the same week of 1926. Reports from 98 cities, having an estimated population of more than 30,600,000 and located in all parts of the country gave a total of 80 cases of this disease as against 54 for the 1926 week. The estimated expectancy based on the experience of the last nine years, excluding epidemics, was 62 cases for these cities.

Smallpox showed a similar increase, 40 States reporting 674 cases for the week this year as compared with 561 for that of 1926. The 98 cities reported 128 cases for the 1927 week and only 88 for that of 1926, while the estimated expectancy was 115 cases.—*U. S. Daily.*

A SUGGESTION TO STATE JOURNALS BY THE COOPERATIVE MEDICAL ADVERTISING BUREAU

DON'T BUY GOLD BRICKS

THE publishers of this JOURNAL believe the readers have a right to trust the advertisements as much as editorials and news.

Therefore, we are careful to investigate the firms and their copy before we make contracts with them.

We will not accept advertisements of medicinal products that are not approved by the Council on Pharmacy and Chemistry of the American Medical Association. Nor will we knowingly print advertisements of any nature that are not believed to be entirely reliable.

We want every reader to say:—"I saw it advertised in my own State Medical Journal and I can safely purchase and prescribe it."

These facts being true, our subscribers should, other things being equal, give preference to the firms, goods, and institutions advertised in these pages. All our advertisers are in the A1 class. They want your patronage and it should be a duty, as well as a privilege, to buy from them.

The lumberman who bought a "gold" brick prided himself on the fact that he never read newspapers. Read the advertisements in this JOURNAL. *Don't buy "Gold" Bricks.*

RECENT DEATHS

KRAUS—DR. DORRIS MAY PRESSON KRAUS died at her home in Needham, June 22, 1927, aged 38. She was a native of Farmington, Me., daughter of Mr. and Mrs. George McL. Presson.

Dr. Kraus was a graduate of the Woman's Medical College of Pennsylvania in 1911, joined the Massachusetts Medical Society in 1922 and settled in Framingham. She was resident physician at the reformatory for women at Sherborn from 1921 to 1925 and became a resident of Needham in 1925. She was a member of the American Psychiatric Association and of the American Society of Psychiatry. She is survived by her husband, Arthur H. Kraus, and a one-year-old daughter.

ROCKWELL—DR. HERBERT GEORGE ROCKWELL, a Fellow of the Massachusetts Medical Society, formerly Councilor from the Hampshire District Medical Society, died suddenly at his home in Amherst, of angina pectoris, June 25, 1927, aged 55.

He was born in Springfield, Vt., May 9, 1872, the son of George and Caroline (Hurd) Rockwell. He graduated from Tilton Academy and the Medical School of the University of Vermont in 1896. He married Marion Marshall of Edinburgh, Scotland, April 13, 1901, while doing post-graduate work at the University of Edinburgh. He settled in practice in Granville, joining the State medical society in 1901. Since 1902 he had lived in Amherst, where he was a member of the First Congregational Church, Pacific Lodge of Masons and other branches of the Masonic fraternity. For 17 years he had served as medical examiner for the district, and during the World War served as lieutenant, later being appointed to the rank of captain in the Reserve Corps.

CORRESPONDENCE

A CARD ISSUED BY THE TRAVELERS INSURANCE COMPANY

I am enclosing original card which was made out by the representative of the Travelers Insurance Company and handed to one of my patients who is an employee of the city of Melrose.

The employee refused to accept the card and it was handed by the agent (Bacon) to Pat Decosse, the timekeeper.

From there it was handed into the engineers' office and from there returned to the employee and loaned by him to me.

This card is obviously self-explanatory and needs no further comment from me.

Personally I am getting fed up on this line of opposition.

Fraternally yours,

W. A. HUTTON, M.D.

THE TRAVELERS INSURANCE COMPANY COMPENSATION SERVICE CARD

IN CASE OF ACCIDENT

IF INJURED EMPLOYEE CAN WALK
SEND HIM TO OFFICE OF

Dr. Forrest F. Pike, 67 Wyoming Ave.

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<i>Paul H. Provandie, 96 W. Emerson St.</i>		
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NAME	ADDRESS	PHONE NO.
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<i>Gordon D. Atkinson, 129 Franklin St.</i>		
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NAME	ADDRESS	PHONE NO.
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NAME	ADDRESS	PHONE NO.
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NAME	ADDRESS	PHONE NO.
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IF INJURED EMPLOYEE CANNOT WALK:

Telephone _____ For

AMBULANCE TO CONVEY HIM TO

HOSPITAL

HOSPITAL

HOSPITAL

SEND IMMEDIATE NOTICE OF ACCIDENT TO

CLAIM DIVISION

THE TRAVELERS INSURANCE COMPANY

FIRST AID SUGGESTIONS

Don't touch wound with anything but sterile gauze from FIRST AID Package.

Paint small wounds with iodine. Don't apply water, peroxide or anything except sterile gauze.

Eye injuries or getting something in eye, leave it alone. Don't try to remove particles. Go to the doctor at once even for slight injuries.

Broken Bones or Severe Injuries

Remove all wreckage without moving patient. Keep him flat and quiet until ambulance arrives.

In Case of Bleeding. Pressure with sterile gauze and bandage over bleeding point. If severe, wind a towel or clothing tightly above the injury, applying tourniquet over same.

DISEASE INCIDENCE IN CONNECTICUT
WEEK ENDING JUNE 18

DISEASE	Week ending May 28	Week ending June 4	Week ending June 11	Week ending June 18	Average cases reported for week corresponding to June 18 for past 7 yrs.	Week ending May 29	Week ending June 5	Week ending June 11	Week ending June 19
Actinomycosis	-	-	1	-	-	-	-	-	-
Anthrax	-	-	-	-	-	-	-	-	-
Botulism	-	-	-	-	-	-	-	-	-
Cerebrospinal Men.	-	-	-	2	1	1	1	1	1
Chickenpox	139	114	123	123	62	46	54	56	93
Conjunctivitis, Inf.	-	-	-	-	-	3	-	-	-
Diphtheria	36	26	31	28	32	14	16	9	15
Dysentery, Amoebic	1	-	-	-	-	-	-	-	-
Dysentery, Bacillary	-	-	-	-	-	-	-	-	-
Encephalitis, Epid.	1	1	1	-	-	1	1	-	-
Favus	-	-	-	-	-	-	-	-	1
German Measles	31	6	5	6	13	64	25	45	19
Hookworm Infection	-	-	-	-	-	-	-	-	-
Influenza	1	4	2	-	1	7	6	3	2
Leprosy	-	1	-	-	-	-	-	-	-
Malaria	-	-	1	1	1	-	-	-	-
Measles	57	44	67	55	158	544	421	444	349
Mumps	75	57	37	47	25	12	5	22	6
Paratyphoid Fever	-	-	-	-	-	-	-	-	-
Pneumonia, Broncho*	26	16	22	19	22*	41	24	30	24
Pneumonia, Lobar	39	20	25	33	17	33	25	39	36
Poliomyelitis	-	-	-	1	-	-	-	-	-
Scarlet fever	76	68	69	56	49	64	60	79	78
Septic Sore Throat	3	1	5	2	-	-	-	-	1
Smallpox	-	-	-	-	2	-	-	1	-
Tetanus	-	-	-	-	-	-	-	-	-
Trachoma	-	1	-	-	-	-	-	-	-
Trichinosis	-	-	-	-	-	-	-	-	-
Tuberculosis	26	17	20	33	34	39	32	28	42
Tuberculosis (o.f.)	3	3	3	4	4	12	4	-	2
Typhoid Fever	1	-	2	1	4	-	1	3	3
Typhus Fever	1	-	-	1	-	-	-	-	-
Whooping Cough	16	39	13	21	43	39	29	44	53
Whooping Cough	51	67	24	26	16	10	5	45	9
Syphilis	32	29	29	21	24	17	13	58	17

*Average for two years. Made reportable January 1, 1925.

Remarks: No cases of cholera, Asiatic, glanders, plague, rabies in humans and yellow fever during the past seven years.

MORBIDITY REPORT FOR THE WEEK ENDING

JUNE 18, 1927

Diphtheria	28	Bronchopneumonia	19	Septic sore throat	2	Typhus fever	1*
Last week	31	Cerebrospinal meningitis	2	Tuberculosis, pulmonary	33	Chancroid	1
Scarlet fever	56	Chickenpox	123	Tuberculosis, other forms	4	Gonorrhea	28
Last week	89	German measles	6			Syphilis	21
Typhoid fever	1	Malaria	1				
Last week	2	Mumps	47				
Measles	55	Ophthalmia	1				
Last week	67	Pneumonia, lobar	33				
Whooping cough	21	Poliomyelitis	1				
Last week	13						

*Omitted from morbidity report last week.

NEWS ITEMS

HONOR TO DR. H. P. WALCOTT—The following tribute to Dr. Henry Pickering Walcott, published in the *Boston Herald*, will be endorsed by the medical profession:

DR. HENRY P. WALCOTT
(From *The Nation*)

Dr. Henry P. Walcott's retirement, because of age, from the corporation of Harvard University, in which he has served for 47 years, must not pass unnoticed in these columns. A distinguished physician, Dr. Walcott became an overseer of the college in 1887 and was appointed a Fellow in 1890. Twice during his long period of service, in 1900 and 1905, he was acting president of the university during long absences of President Eliot, whose devoted lieutenant he always was. A wise and far-sighted counselor, Dr. Walcott's modesty has prevented adequate appreciation of his devoted labors for the advancement of Harvard University and of university education everywhere. More than that, Dr. Walcott has been one of those great unofficial statesmen with whom America is blessed in richer measure than is generally understood. That appears from the fact that he is an ex-president of the Massachusetts Medical Society and the American Public Health Association, head of the American Academy of Arts and Sciences, and a trustee of the Carnegie Institution. Long chairman of the board of trustees of the Massachusetts General Hospital, he was also president of the International Congress on Hygiene and Demography in Washington in 1912. In addition, Dr. Walcott has rendered inestimable service to the Commonwealth of Massachusetts as chairman of its Board of Health—he has written portions of every annual report of this State board since 1882—and as chairman of the Metropolitan Water and Sewerage Board, which has done so much to beautify and sanitize the neighborhood of Boston and to supply pure water to the people. Fortunate are a university and a State which have had the services of such a citizen for so long a period.

CELEBRATION AT THE SORBONNE IN MEMORY OF PHILIPPE PINEL—Pinel, a French specialist in mental diseases, died in 1826, and, on May 30, 1277 scientists and physicians met at the Sorbonne to pay tribute to the memory of this man, who is regarded as the first to regard insanity as a disease and apply humane methods of treatment for these unfortunates.

HONOR TO MASSACHUSETTS—The State of Utah and the Province of Nova Scotia have recently employed Dr. George L. Wallace, superintendent of the Wrentham State School, to suggest plans for dealing with the mentally deficient.

RESERVE FUND FOR THE MASSACHUSETTS SOCIETY FOR MENTAL HYGIENE—The campaign for gifts of money to provide a reserve fund for this social welfare organization has not reached its goal of \$5000.

Contributions will be gratefully received and will be used to enable the society to prosecute a work which is of great advantage to individuals and the State. This society will provide speakers who will address gatherings on mental hygiene subjects.

NOTICES

APPROVAL OF ANTIVENIN

In addition to the articles enumerated in our letter of May 28, the following have been accepted:

H. K. Mulford Company
Antivenin (Nearctic Crotalidae)—Mulford.

Yours truly,

W. A. PUCKNER, *Secretary*,
Council on Pharmacy and Chemistry.

UNITED STATES PUBLIC HEALTH SERVICE

CHRONOLOGICAL LIST OF CHANGES OF DUTIES AND STATIONS OF COMMISSIONED AND OTHER OFFICERS OF THE UNITED STATES PUBLIC HEALTH SERVICE

JUNE 15, 1927

P. A. Surgeon K. F. Maxcy—Directed to proceed from New Orleans, La., to Crowley, La., June 3, and return, for duty in connection with the prevention of the interstate spread of smallpox and other epidemic diseases in the flooded area—June 1, 1927.

Surgeon W. C. Rucker—Directed to proceed from New Orleans, La., to Crowley, La., June 3, and return, for duty in connection with the prevention of the interstate spread of smallpox and other epidemic diseases in the flooded area. Also directed to proceed from New Orleans, La., to Chicago, Ill., June 9, and return, for conference with the Medical Officer in charge of U. S. M. H. No. 5—June 1, 1927.

Sanitary Engineer L. C. Frank—Directed to proceed from Chicago, Ill., to New York City, June 9, stopping en route at Washington, D. C., for conference at the Bureau, in connection with milk studies—June 6, 1927.

Surgeon R. R. Spencer—Directed to proceed from Hamilton, Mont., to such places in Colorado and New Mexico as may be necessary, and return, in connection with the study and prevention of Rocky Mountain spotted fever—June 7, 1927.

Assistant Surgeon General Thomas Parran, Jr.—Directed to proceed from Washington, D. C., to Minneapolis, Minn., and return, to attend a meeting of the State Sanitary Conference of State and local health authorities to be held June 14-16. Also directed to proceed from Washington, D. C., to White Sulphur Springs, W. Va., and return, to attend a meeting of the West Virginia State Medical Association to be held June 21-23—June 8, 1927.

Surgeon J. H. Linson—Relieved from duty at Norfolk, Va., and assigned to duty at U. S. M. H. No. 5, Chicago, Ill.—June 9, 1927.

Surgeon H. McG. Robertson—Relieved from duty at Boston, Mass., and assigned to duty at Ellis Island, N. Y.—June 9, 1927.

Surgeon L. L. Williams, Jr.—Directed to proceed from Richmond, Va., to Washington, D. C., June 20, and return, for conference at the Bureau—June 9, 1927.

Dental Surgeon (R) C. T. Messner—Directed to proceed from Washington, D. C., to New York City, June 19, and return, to inspect dental activities of the Service in that city—June 9, 1927.

Assistant Surgeon G. T. Sprague—Relieved from duty at San Francisco, Calif., and assigned to duty at U. S. M. H. No. 9, Fort Stanton, N. M.—June 9, 1927.

Acting Assistant Surgeon R. W. Flynn—Assigned to duty at U. S. M. H. No. 5, Chicago, Ill.—June 9, 1927.

Acting Assistant Surgeon J. W. Levy—Relieved from duty at Little Rock, Ark., and assigned to duty at Hot Springs, Ark., in connection with venereal disease control activities of the Service—June 9, 1927.

Surgeon R. H. Creel—Directed to proceed from San Francisco, Calif., to Los Angeles, Calif., and return, for conference regarding matters relating to the care of Service beneficiaries—June 10, 1927.

Acting Assistant Surgeon B. F. Bond—Directed to proceed from Savannah, Ga., to Washington, D. C., and return, to accompany a patient to St. Elizabeth's Hospital—June 10, 1927.

Acting Assistant Surgeon Charles P. Waite—Assigned to duty with the United States Bureau of Mines, Washington, D. C.—June 10, 1927.

Assistant Surgeon (R) George D. Boone—Relieved from duty at Stapleton, N. Y., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans, La., to

such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Surgeon R. M. Grimm—Directed to proceed from Washington, D. C., to Owings Mills, Md., June 15, and return, in connection with investigations of mental hygiene—June 13, 1927.

Surgeon Lawrence Kolb—Directed to proceed from Washington, D. C., to Owings Mills, Md., and return, June 15, in connection with investigations of mental hygiene—June 13, 1927.

Surgeon G. C. Lake—Relieved from duty at Washington, D. C., and assigned to duty at U. S. M. H. No. 21, Stapleton, N. Y.—June 13, 1927.

Assistant Surgeon A. J. Aselmeyer—Directed to proceed from Washington, D. C., to Owings Mills, Md., June 15, and return, in connection with investigations of mental hygiene—June 13, 1927.

Assistant Surgeon K. K. Bryant—Relieved from duty at Stapleton, N. Y., and assigned to duty at Ellis Island, N. Y.—June 13, 1927.

Assistant Surgeon R. A. Vonderlehr—Directed to proceed from Washington, D. C., to Owings Mills, Md., June 15, and return, in connection with investigations of mental hygiene—June 13, 1927.

Assistant Surgeon (R) George W. Buchanan—Relieved from duty at Stapleton, N. Y., and assigned to duty at U. S. M. H. No. 82, Norfolk, Va.—June 13, 1927.

Assistant Surgeon (R) H. J. Bush—Ordered to duty under terms of commission and directed to proceed from Jeannette, Pa., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 13, 1927.

Assistant Surgeon (R) R. W. Cranston—Ordered to duty under terms of commission and directed to proceed from Cloquet, Minn., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 13, 1927.

Assistant Surgeon (R) T. G. Estes—Ordered to duty under terms of commission and directed to proceed from Waxahachie, Texas, to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 13, 1927.

Assistant Surgeon (R) H. N. Fisher—Ordered to duty under terms of commission and directed to proceed from St. Louis, Mo., to San Francisco, Calif., for assignment to duty at U. S. M. H. No. 19—June 13, 1927.

Assistant Surgeon (R) M. A. Gilmore—Ordered to duty under terms of commission and directed to proceed from Braddock, Pa., to Stapleton, N. Y., for assignment to duty at U. S. M. H. No. 21—June 13, 1927.

Assistant Surgeon (R) E. L. Graydon—Ordered to duty under terms of commission and directed to proceed from Atlanta, Ga., to Baltimore, Md., for assignment to duty at U. S. M. H. No. 1—June 13, 1927.

Assistant Surgeon (R) A. C. Grimes—Ordered to duty under terms of commission and directed to proceed from Nashville, Tenn., to Norfolk, Va., for assignment to duty at U. S. M. H. No. 82—June 13, 1927.

Assistant Surgeon (R) L. J. Hand—Relieved from duty at Chicago, Ill., and assigned to duty at U. S. M. H. No. 2, Boston, Mass.—June 13, 1927.

Assistant Surgeon (R) S. F. Hatchette—Ordered to duty under terms of commission and directed to proceed from Marion, Ala., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 13, 1927.

Assistant Surgeon (R) R. B. Holt—Ordered to duty under terms of commission and directed to proceed from Nashville, Tenn., to Stapleton, N. Y., for assignment to duty at U. S. M. H. No. 21—June 13, 1927.

Assistant Surgeon (R) D. A. Kendall—Ordered to duty under terms of commission and directed to pro-

ceed from Great Bend, Kan., to Norfolk, Va., for assignment to duty at U. S. M. H. No. 82—June 13, 1927.

Assistant Surgeon (R) C. D. Kosar—Relieved from duty at Stapleton, N. Y., and assigned to duty at U. S. M. H. No. 70, New York City—June 13, 1927.

Assistant Surgeon (R) C. M. Miller—Ordered to duty under terms of commission and directed to proceed from Edenwald, Tenn., to San Francisco, Calif., for assignment to duty at U. S. M. H. No. 19—June 13, 1927.

Assistant Surgeon (R) J. R. Murdock—Relieved from duty at San Francisco, Calif., and assigned to duty at U. S. P. H. S. Relief Station No. 329, Washington, D. C.—June 13, 1927.

Assistant Surgeon (R) E. W. Norris—Ordered to duty under terms of commission and directed to proceed from Omaha, Neb., to San Francisco, Calif., for assignment to duty at U. S. M. H. No. 19—June 13, 1927.

Assistant Surgeon (R) J. H. Ready—Ordered to duty under terms of commission and directed to proceed from Kansas City, Mo., to San Francisco, Calif., for assignment to duty at U. S. M. H. No. 19—June 13, 1927.

Assistant Surgeon (R) D. P. Ross—Ordered to duty under terms of commission and directed to proceed from Philadelphia, Pa., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 13, 1927.

Assistant Surgeon (R) P. A. Shelburne—Ordered to duty under terms of commission and directed to proceed from Richmond, Va., to Baltimore, Md., for assignment to duty at U. S. M. H. No. 1—June 13, 1927.

Assistant Surgeon (R) R. A. Steere—Ordered to duty under terms of commission and directed to proceed from Omaha, Neb., to San Francisco, Calif., for assignment to duty at U. S. M. H. No. 19—June 13, 1927.

Assistant Surgeon (R) B. J. Tynan—Ordered to duty under terms of commission and directed to proceed from Omaha, Neb., to Chicago, Ill., for assignment to duty at U. S. M. H. No. 5—June 13, 1927.

Assistant Surgeon (R) George R. Welch—Relieved from duty at New Orleans, La., and assigned to duty at U. S. M. H. No. 21, Stapleton, N. Y.—June 13, 1927.

Sanitary Engineer Leslie C. Frank—Bureau order of June 1, 1927, directing him to proceed from Montgomery, Ala., to Jackson, Miss., to attend the State Social Welfare Conference to be held June 23-24, revoked—June 14, 1927.

Assistant Surgeon (R) E. M. Gordon—Ordered to duty under terms of commission and directed to proceed from Westwego, La., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 14, 1927.

Assistant Surgeon (R) H. F. Whalman—Ordered to duty under terms of commission and directed to remain on duty at U. S. M. H. No. 19, San Francisco, Calif.—June 14, 1927.

BOARDS CONVENED

A board of officers convened to meet at Philadelphia, Pa., at the call of the chairman, to reexamine an alien—June 10, 1927. Detail for the board: Surgeon H. E. Trimble, A. A. Surgeon Leon Van Horn, A. A. Surgeon Horace Phillips.

A board of officers convened to meet at New York City, June 23, 1927, to determine the physical eligibility of candidates for appointment as cadets in the United States Coast Guard—June 14, 1927. Detail for the board: P. A. Surgeon (R) F. A. King, Assistant Surgeon (R) C. D. Kosar.

Official:

H. S. CUMMING, *Surgeon General.*

CHRONOLOGICAL LIST OF CHANGES OF DUTIES AND STATIONS OF COMMISSIONED AND OTHER OFFICERS OF THE UNITED STATES PUBLIC HEALTH SERVICE

JUNE 22, 1927

Assistant Surgeon (R) T. C. Klenzle—Relieved from duty at U. S. M. H. No. 14, New Orleans, La., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) E. T. Lentz—Relieved from duty at Chicago, Ill., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) W. J. B. McAuliffe—Relieved from duty at Baltimore, Md., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) W. W. Nesbit—Relieved from duty at Norfolk, Va., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) L. O. Parker—Relieved from duty at Stapleton, N. Y., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) C. B. Stacy—Relieved from duty at U. S. M. H. No. 14, New Orleans, La., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Assistant Surgeon (R) J. F. Van Akeren—Relieved from duty at U. S. M. H. No. 14, New Orleans, La., and assigned to duty at New Orleans, La., in connection with flood work. Also directed to proceed from New Orleans to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana, as may be necessary, and return, in connection with such work—June 11, 1927.

Surgeon J. G. Townsend—Relieved from duty at Pendleton, Ore., and assigned to duty at Little Rock, Ark., in connection with flood work. Also directed to proceed from Little Rock to such places in the States of Tennessee, Kentucky, Missouri, Mississippi, Arkansas and Louisiana as may be necessary, and return, in connection with such work—June 13, 1927.

Surgeon J. P. Leake—Directed to proceed from Washington, D. C., to Montreal, Can., and to such other points in the surrounding territory and in the New England States as may be necessary, and return, to investigate an epidemic of typhoid fever—June 16, 1927.

Surgeon L. L. Lumsden—Directed to proceed from Washington, D. C., to Montreal, Can., and to such other points in the surrounding territory and in the New England States as may be necessary, and re-

turn, to investigate an epidemic of typhoid fever—June 16, 1927.

Surgeon C. E. Waller—Directed to proceed from Washington, D. C., to Montreal, Can., and to such other points in the surrounding territory and in the New England States as may be necessary, and return, to investigate an epidemic of typhoid fever—June 16, 1927.

Sanitary Engineer H. R. Crohurst—Directed to proceed from Minneapolis, Minn., to Montreal, Can., and to such other points in the surrounding territory and in the New England States as may be necessary, and return, to investigate an epidemic of typhoid fever—June 16, 1927.

Assistant Surgeon General W. F. Draper—Directed to proceed from Washington, D. C., to Richmond, Va., June 17, and return, for conference with officials of the State Board of Health regarding measures for the sanitary control of shellfish—June 17, 1927.

Surgeon C. P. Knight—Relieved from duty at Balboa Heights, Canal Zone, and directed to proceed to Washington, D. C., and report to the Surgeon General for duty—June 17, 1927.

Passed Assistant Surgeon K. F. Maxcy—Directed to proceed from Washington, D. C., to Rockhill, S. C., and return, in connection with field investigations of typhus fever—June 17, 1927.

Surgeon G. W. McCoy—Directed to proceed from Washington, D. C., to Rockford, Ill., and return, in connection with field investigations of smallpox—June 17, 1927.

Acting Assistant Surgeon Roy R. Jones—Relieved from duty at Washington, D. C., and assigned to duty at Johnstown, Pa., in connection with field investigations of industrial hygiene—June 18, 1927.

Surgeon W. H. Frost—Directed to proceed from Baltimore, Md., to Washington, D. C., June 20, and return, for conference in connection with field investigations of industrial hygiene—June 20, 1927.

Assistant Surgeon (R) W. C. Brann—Ordered to duty under terms of commission and directed to proceed from Bluefield, W. Va., to Stapleton, N. Y., for assignment to duty at U. S. M. H. No. 21—June 20, 1927.

Assistant Surgeon (R) H. G. Foster—Ordered to duty under terms of commission and directed to proceed from Philadelphia, Pa., to Norfolk, Va., for assignment to duty at U. S. M. H. No. 82—June 20, 1927.

Assistant Surgeon (R) J. R. Gill—Ordered to duty under terms of commission and directed to proceed from University, Va., to New Orleans, La., for assignment to duty at U. S. M. H. No. 14—June 20, 1927.

Assistant Surgeon (R) S. J. Hall—Ordered to duty under terms of commission and directed to proceed from Louisville, Ky., to Baltimore, Md., for assignment to duty at U. S. M. H. No. 1—June 20, 1927.

Assistant Surgeon (R) H. O. Veach—Ordered to duty under terms of commission and directed to proceed from Beatrice, Neb., to Stapleton, N. Y., for assignment to duty at U. S. M. H. No. 21—June 20, 1927.

APPOINTMENTS

Ralph Horton appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Gerald M. Kunkel appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Edmond T. Lentz appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

W. J. Bryan McAuliffe appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Fred W. Caudill appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Albert S. Irving appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

William W. Nesbit appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

George D. Boone appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Leon O. Parker appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Bernard J. Macauley appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Charles B. Stacy appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

John R. Murdock appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Thomas C. Kienle appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Cecil C. Swann appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Leo J. Hand appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

George R. Welch appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

George W. Buchanan appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Clarence D. Kosar appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Joseph F. Van Ackeren appointed and commissioned in the grade of Assistant Surgeon, effective date of oath.

Official:

H. S. CUMMING, *Surgeon General.*

PUBLICATIONS ISSUED BY PUBLIC HEALTH SERVICE ON CARE OF HEALTH TO EDUCATE PUBLIC.

In excess of 2,000 copies of various publications have been distributed.

The list of Service publications now includes more than 2,000 separate titles. Many of these are of a technical nature, but a large number have been prepared for the use of the general public, and have been distributed in large quantities.

The following is a list of some of the most popular Service publications, showing the number of copies that have been distributed:

Miscellaneous Publication No. 17, "Prevention of Disease and Care of the Sick," 254,553 copies. This publication is a book of 318 pages, and has proved so popular that several editions have been issued.

Reprint No. 707, "Good Teeth," 69,160 copies.

Reprint No. 727, "Care of the Baby," 80,650 copies.

Reprint No. 654, "Nutrition in Childhood," 58,250 copies.

"Keep Well Series" No. 1, "Road to Health," 408,950 copies.

Supplement No. 16, "Summer Care of Infants," 577,936 copies.

Supplement No. 18, "Malaria Primer," 521,750 copies.

Supplement No. 30, "Common Colds," 320,700 copies.

"Keep Well Series" No. 6, "Cancer," 100,000 copies.

"Keeping Fit," 467,450 copies.

"The Parents' Part," 460,850 copies.

These last two mentioned pamphlets were considered so useful that various State Boards of Health either purchased large quantities of these pamphlets from the Government Printing Office or reprinted them at their own expense. During the period 1915 to 1926 the State Boards of Health reprinted these two publications in the quantities indicated: "Keep Fit," 3,711,490; "The Parents' Part," 3,442,092.

As at present constituted, the section aims to constitute itself a national center or clearing house on the subject of public health education. Mimeographed bulletins are prepared and issued to newspapers, publishing agencies, and individuals. These deal largely with the results of studies and investigations made by the Public Health Service.—*United States Daily.*

REPORTS AND NOTICES OF MEETINGS

CLINICAL CONGRESS CONNECTICUT STATE MEDICAL SOCIETY, SEPTEMBER 20TH, 21ST, 22D, 1927

PRELIMINARY PROGRAM

At this time it may be announced that there will be about twenty papers presented during the days of the Congress, and two evening sessions.

The following titles and speakers have been definitely arranged:

1. Vaccination (with demonstration): Dr. James Payton Leake, U. S. P. H. S., Washington, D. C.
2. Treatment of Chronic Nephritis: Dr. Frederick M. Allen, Morristown, N. J.
3. Asthma—Its Classification and Treatment: Dr. Francis Minot Rackemann, Boston, Mass.
4. Drug Rashes: Dr. Fred Wise, New York City.
5. The Use of Iodine in Thyroid Disease: Dr. Charles Gordon Heyd, New York City.
6. Syphilis of the Liver: Dr. Thomas McCrae, Philadelphia, Pa.
7. Mouth Infections and Their Relations to Physical Disabilities: Dr. Leroy M. S. Miner, Boston, Mass.
8. Surgery of the Gall Bladder: Dr. John Frederick Erdmann, New York City.
9. Management of Minor Injuries: Dr. John J. Moorhead, New York City.
10. Clinical Picture Produced by Obstetrical Injuries to the Spinal Cord: Dr. Bronson Crothers, Boston, Mass.
11. Caesarean Section—Its Indications and Its Dangers: Dr. J. Whitridge Williams, Baltimore, Md.
12. Significance of Chronic Sinus Infection: Dr. Ross Hall Skillern, Philadelphia, Pa.
13. Common Foot Conditions: Dr. Frank Ober, Boston, Mass.
14. Newer Industrial Toxic Hazards: Professor Frederick B. Flinn, Department of Physiology, Columbia University.
15. Eye-grounds and Their Diagnoses: Dr. G. E. de Schweinitz, Philadelphia, Pa.
16. Surgery of the Large Intestine: Dr. E. H. Pool, New York City.

Evening Meeting—September 21st.

Socialization of Medical Practice: Dr. Morris Fishbein, Chicago, Ill.

The meetings of the Congress will be held in Sprague Memorial Hall in College Street, at the corner of Wall.